Commonwealth of Kentucky
Public Employee Health Insurance Program
Annual Report

Prepared for:

Commonwealth of Kentucky
Governor
General Assembly
And
Chief Justice of the Supreme Court

October 1, 2001

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Glossary

Adverse Selection – The additional cost that results when an individual selects a health plan that minimizes employee out of pocket expenses and maximizes cost to the health plan.

Brand Name Drug – A trademarked drug for which the manufacturer holds the patent or has purchased the rights to manufacture from the patent holder. Brand name drugs are generally more expensive than generics.

Capitation – A set amount of money paid to a provider of service based on membership demographics. Payment is designed to cover all services provided rather than on services delivered and usually expressed in units of PMPM (per member per month).

Claim – A billed amount for services or goods obtained from a healthcare provider.

COBRA Beneficiaries - Individuals who no longer meet the eligibility requirements for healthcare coverage through a group health plan, but by federal statute, are eligible to continue their healthcare coverage for a period of time under the employer's healthcare program by paying 102% of the total premium rate.

Co-Payment – A stipulated dollar amount that a health plan member must pay out of pocket when healthcare services, supplies, or prescription drugs are received.

Coinsurance – A percentage of the cost of covered healthcare services, supplies, or prescription drugs that a health plan member must pay out of pocket.

Coverage Tier also referred to as Coverage Level – The choices available to employees with respect to the individuals they wish to cover under an employer's health insurance program. Under the Commonwealth's Public Employee Health Insurance Program, the following tiers (or levels) apply:

- Single – coverage for only the employee or retiree
- Couple – coverage for the employee or retire and his/her spouse
- Parent Plus – coverage for the employee and all eligible children
- Family - coverage for the employee or retiree, his/her spouse and all eligible children

Dependent Subsidy – When an employer specifically pays a portion, or all, of the dependent premium for an employee, this is an *explicit dependent* subsidy. When the differential between single and dependent healthcare premium rates is less than the differential between employee/retiree healthcare claims and dependents' healthcare claims, an *implicit dependent subsidy* exists.

EPO – Exclusive Provider Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, EPO Option C was added to the Commonwealth's Public Employee Health Insurance Program.

Formulary – A preferred list of medications developed by a health plan or Pharmacy Benefit Manager (PBM) to guide physician prescribing and pharmacy dispensing. This list is periodically updated by the PBM to add or remove drugs.

Formulary Rebates – Rebates available to a PBM determined by their ability to demonstrate "value" to the manufacturer, primarily by formulary inclusion and by moving market share to a preferred product within the formulary.

FSA – Flexible Spending Account – A flexible spending account or reimbursement account is funded by employee salary reductions, employer contributions or both. Amounts placed in these accounts are used to provide reimbursement for eligible expenses incurred by the employee or eligible beneficiaries for specified benefits during a plan year.

Fully Insured - also referred to as Insured or Fully Funded - When a health plan assumes the financial risk associated with medical expenses for an employer group in exchange for the premiums paid by the group.

Generic Drug - A drug whose therapeutical ingredients are the same as a brand name drug, but which is sold under a name that is not trademarked. Generic drugs are usually less expensive than their brand name counterpart.

HMO – Health Maintenance Organization - These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

Medical Loss Ratio also referred to as Loss Ratio - The ratio between the incurred claims paid by a health plan and the premium taken in by the health insurer. Example: An insurance company receives $100,000 in premium for a month and pays out $89,000 in claims – the Medical Loss Ratio is 89% ($89,000/$100,000).

Out-of-Pocket Limt – A specified dollar amount present in some health plan provisions that limits the amount of out-of-pocket expenses a plan participant pays in a Plan Year for covered health care services. Once the participant reaches the out-of-pocket limit, the health plan pays 100% of his/her covered healthcare expenses for most or all services.

PBM – Pharmacy Benefit Manager – An organization that functions as a third party administrator for a health plan's pharmacy claims, contracts and management.

POS – Point of Service - These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.

Preferred Provider Organization (PPO) - These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.

Premium – The monetary amount paid by an employee or the employer for health insurance benefits. Routinely paid on a monthly basis. In an insured program, the amount paid to an insurance company in exchange for its payment of all healthcare costs covered under the terms of the health plan and for administrative services. For large groups, like the Commonwealth Group, premiums are determined based on the healthcare services consumed by the plan's members in the past and the prices charged by healthcare providers. If the premiums charged by the insurer are less than the actual healthcare costs incurred by the plan's members and the insurer's operating costs, the insurer loses money. The premium includes both the employer's and employees' contributions for health insurance.

Provider Network – A list of contracted health care providers, unique to a health plan, from which an insured can obtain services that are covered under an HMO or are covered at a preferred benefit level under a POS or PPO.

Self Funded – also referred to as Self Insured – A health plan whose medical claims' financial risk is assumed by the employer and not by the health plan.

Stop Loss Coverage - Stop loss coverage is insurance that covers a health plan's expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). This coverage is also referred to as **Excess Loss Coverage.**

Third Party Administrator (TPA) – An organization that performs health insurance administrative functions (e.g. claims processing) for a plan or an employer. The TPA may also provide the healthcare provider network.

Waiver - An eligible employee or retiree who declines health care coverage through his/her employer for a plan year. Often the employee obtains health care coverage through another means, typically a spouse's employer or an individual policy.

Executive Summary

Following a thorough review of the Commonwealth's Public Employee Health Insurance Program, the Kentucky Group Health Insurance Board makes the recommendations outlined in this section. Findings from the comprehensive analysis conducted by the Board, upon which these recommendations are based, are summarized in the final section of this report. Additional detail is presented in the individual sections of this report.

Commonwealth Contribution Structure and Dependent Subsidies

Consistent with the basic tenet that all employees and retirees be treated equally, regardless of their need for health insurance for themselves and/or their dependents, and the commitment made to employees by the Commonwealth in the past, the Board recommends that the Commonwealth:

- Continue to pay the full cost of individual healthcare coverage under the lowest cost Option A in each county, with a specific minimum, monthly defined dollar contribution. When establishing its defined dollar contribution, the Board suggests that the Commonwealth consider anticipated increases in health care costs.
- Continue to provide an alternative healthcare flexible spending account (FSA) benefit to individuals who waive health insurance coverage through the Commonwealth Group, at the level currently in effect.
- Provide only one Commonwealth health insurance contribution to each individual who is eligible to participate in the Commonwealth Group, including every eligible retiree who is also an eligible active employee, irrespective of his/her former or current employer. Allow individuals who would otherwise qualify for more than one Commonwealth contribution to decide which contribution he/she wishes to receive.

However, the Board believes that the funds appropriated by the Commonwealth for employee/retiree health insurance should be restricted to use for employee/retiree healthcare benefits. Therefore, the Board recommends that, consistent with KRS 18A.225(2)(g), the Commonwealth should:

- Recoup forfeitures from the healthcare flexible spending accounts funded by the Commonwealth, for those who waive health insurance, from ***all*** entities that participate in the Commonwealth Group and return these to the Commonwealth's Public Employee Health Insurance Program, to the extent permissible by federal standards. Based on the 1999 and 2000 experience of state agencies, these forfeitures are estimated to be about $18 million in 2001.[1]

Additionally, to make health insurance coverage more affordable for employees' dependents and to bring the Commonwealth's program more in line with those of other states, the Board recommends that the Commonwealth:

- Subsidize the cost of dependent health insurance premiums, to the extent financially feasible without impacting the ability to provide single coverage under the lowest cost Option A at no

[1] *Based on data provided by the Personnel Cabinet and projections by William M. Mercer, Incorporated*

employee contribution. The Commonwealth should also retain the implicit dependent subsidies currently present in the Commonwealth's Public Employee Health Insurance Program as a result of the relationship between single and dependent premium rates.

Because the Commonwealth does not subsidize the cost of dependent health insurance coverage, as do the majority of other states (88%), dependent healthcare premiums paid by members of the Commonwealth Group are substantially higher than the average of other states.[2] This may result in a continuing decline in the number of Commonwealth employees/retirees electing dependent healthcare coverage, as occurred in 2000. Given the Commonwealth's current budget situation and expected double digit health insurance cost increases for the foreseeable future, like occurred in 2000, the Board researched several options that might be pursued to provide funding for dependent health insurance premium subsidies, in case additional funds could not be appropriated for this purpose. These include:

- Recouping an estimated $18 million in forfeitures from the healthcare flexible spending accounts of individuals waiving health insurance through the Commonwealth Group, as recommended by the Board above.
- Placing an assessment of around $10 million on entities whose retirees participate in the Commonwealth Group but whose active employees do not, as outlined in the Board's recommendations regarding Adverse Selection which follow.
- Reducing the Commonwealth's contribution to healthcare flexible spending accounts of individuals who waive health insurance through the Commonwealth Group by 50%, resulting in estimated funds of around $20 million annually, or $38 million in total if all FSA forfeitures are also recouped. An option ***not*** adopted by the Board as a recommendation.
- Revising the Commonwealth's funding of single health insurance coverage from 100% of the premium for single coverage under the lowest cost Option A available in every county to 90%, resulting in estimated funds of roughly $27 million annually. Another option ***not*** adopted by the Board as a recommendation.

In aggregate, it is estimated that, if the Commonwealth implemented all of these revisions, there would be $75 million available, enough to fund up to 35% of the premium cost for dependent health insurance coverage. Additional details about the options that would entail changes in the Commonwealth's funding of healthcare flexible spending accounts and single health insurance coverage are provided in the Dependent Coverage section of this report.

Benefit Levels

With respect to the provisions of the health insurance options the Commonwealth offers to Commonwealth Group members:

- Consistent with the input received from the Employee Advisory Committee, the Board's consensus recommendation is to maintain the current level of benefits, to the extent possible. Otherwise, modify these provisions over time to continue to stay in line with other states' employee healthcare programs.
- Provide employees/retirees the opportunity to save up to 33 1/3% of their co-payments for maintenance prescription drugs by implementing a mail order pharmacy feature with co-

[2] *2001 Survey of other states conducted by OPEHI and William M. Mercer, Incorporated*

payments for a 90-day supply of maintenance drugs equal to 2 times the retail pharmacy co-payment for a 30-day supply of the same drug. It is estimated that this feature could save the Commonwealth's Public Employee Health Insurance Program up to 1% of its prescription drug costs for every 10% of prescriptions filled through mail order rather than a retail pharmacy.

- Investigate other pharmacy initiatives such as purchasing pools, co-pay/ co-insurance structures, multiple tiers, etc. to obtain the most cost effective prescription drug benefits for the Commonwealth's Public Employee Health Insurance Program and its members.

Adverse Selection Mitigation

In any health insurance program that offers its members a choice of healthcare options, adverse selection will exist. To mitigate the cost impact of adverse selection, to the extent possible, while preserving participant choice, the Board recommends that the Commonwealth:

- Maintain the current prescribed premium rate relationship between Single, Couple, Parent+ and Family coverage levels. Additionally, maintain the specified range of premium rate differential between the A and B options offered to Commonwealth Group members, as designated in the Commonwealth's 2002 health insurance Request for Proposal (RFP).
- Continue to require health insurers who provide coverage to Commonwealth Group members to rate all members of the program (with the potential exception of retirees whose corresponding actives do not participate in Commonwealth's Public Employee Health Insurance Program) together so that a given insurer offers the same option at the same price wherever it is offered within the Commonwealth. Additionally, continue to require all Commonwealth Public Employee Health Insurance Program insurers to allow out-of-state retirees to participate in any healthcare option they offer within the Commonwealth that has out-of-network benefits.
- Retirees of groups whose active employees do not participate in the Commonwealth's Public Employee Health Insurance Program, and their covered dependents, added about $10 million in excess cost that was absorbed by the Commonwealth or other Commonwealth Group members in 2000.[3] Therefore, either:

  Require the active employees of all entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program to also participate.

  or

  Require entities whose retirees participate in the Commonwealth's Public Employee Health Insurance Program to be responsible for the actuarial difference in cost of their retirees.
- Due to the cost impact of allowing individuals to "buy into" a group health insurance program, as illustrated by the average healthcare cost of Commonwealth Group COBRA members, which was 2 ½ times the average cost of other Commonwealth Group members in 2000,[4] restrict membership in the Commonwealth Group to public employees and retirees.
- Limit the ability of entities to enter and exit the Commonwealth Group through statutory language that stipulates that once an entity participates in the Commonwealth's Public

[3] *The MedStat Group based on data submitted by Commonwealth Group insurers.*

[4] *Calculated by William M. Mercer, Incorporated based on data submitted by Commonwealth Group insurers.*

Employee Health Insurance Program, it must remain in the program until such time as it no longer participates in a state sponsored retirement plan.

- Do not risk adjust the premiums paid to the Commonwealth's health insurance carriers based on the age, gender, and/or health status of plan enrollees, as this type of risk adjustment is controversial since it results in premium adjustments after individuals have selected the health plan in which they wish to enroll.

Self Funding

In a self-funded arrangement, if healthcare claims and expenses exceeded projections, the Commonwealth would incur a deficit. As the total expenditures of the Commonwealth's Public Employee Health Insurance Program are expected to exceed $600 million in 2002, if claims and expenses exceeded projections by 5%, a deficit of over $30 million would result. In the first year of self-funding, this level of variance is more likely to occur due to changes in provider network composition, provider reimbursement arrangements, and/or claims and care management that may result from vendor changes. Additionally, in periods of increasing healthcare trends, as is the case currently, there is a greater probability that actual costs will deviate from projected costs. Therefore, the Board recommends that the Commonwealth:

- Only self-fund its Public Employee Health Insurance Program, if it is highly likely that the risk it would be accepting would be offset by substantial cost savings, after taking into account not only projected claims, re-insurance premiums and third party administrator costs, but also the cost of additional Commonwealth staff required.
- Consider the impact on the overall health insurance market in Kentucky, if it were to self-fund, since the Commonwealth comprises approximately 20% of the individuals with insured healthcare benefits in the entire state.

Healthcare Third Party Administrator and Vendor Evaluation

As part of continuous quality improvement, the Board recommends that OPEHI:

- Conduct on-site reviews to validate performance results reported by the Commonwealth's Public Employee Health Insurance Program insurance carriers and/or third party administrators, including:
  - claims and eligibility audits to assess the timeliness, financial accuracy and claim coding accuracy of claims processed;
  - operational reviews to evaluate staffing, systems, policies and procedures; and
  - customer service assessments to determine the quality and timeliness of customer service delivered to Commonwealth Group members.

Board Input

To provide ongoing, broader input to the management of the Commonwealth's Public Employee Health Insurance Program:

- establish a permanent Board, and
- include a representative from the legislative branch of government and a judicial representative in the Board's composition.

Scope and Process

In accordance with the provisions of KRS 18A.226(5)(b), enacted by the 2000 General Assembly as a component of Senate Bill 288, this document comprises the first annual report from the Kentucky Group Health Insurance Board to the Governor, the General Assembly, and the Chief Justice of the Supreme Court. It includes:

- A summary of the experience of the Commonwealth's Public Employee Health Insurance Program (CPEHIP) through December 2000;
- Comparisons of the Commonwealth's Public Employee Health Insurance Program to other states' employee health insurance programs;
- An analysis of dependent healthcare coverage within the Commonwealth's Public Employee Health Insurance Program and estimated costs if the Commonwealth were to subsidize the cost of dependent healthcare coverage;
- A discussion of options researched by the Board to provide funding to subsidize the cost of dependent health insurance premiums;
- A discussion of adverse selection, actions the Commonwealth has taken to-date to mitigate the effects of selection on the cost of the Commonwealth's Public Employee Health Insurance Program, and other adverse selection mitigation methods;
- An evaluation of self-funding and issues the Commonwealth should consider before embarking on this path; and
- A description of strategies for evaluating healthcare third party administrators (TPAs) and vendors.

To prepare this report, research was conducted by the Office of Public Employee Health Insurance and William M. Mercer, Incorporated and presented to the Board at its monthly meetings. Based on these presentations and the Board's articulated recommendations, the report was drafted by William M. Mercer, Incorporated on behalf of the Board and modified to incorporate the Board's comments.

Please refer to the *Glossary* at the beginning of this report for definitions of terms used in the body of the report.

Background and History

The *Health Insurance Market for Employees and Retirees of Kentucky State Government – Research Report No. 286*, dated August 12, 1999, prepared by the Program Review & Investigations Committee Staff, provides the following historical information regarding the Commonwealth's Public Employee Health Insurance Program.

> *The Commonwealth first contributed funds for the health insurance premiums of its employees in 1972. From that time until the mid 1980's, Blue Cross & Blue Shield was the only insurance carrier offered to the state group. After experimenting with two HMO plans in 1981 and 1983, the Personnel Cabinet made more than a dozen additional plans, mostly HMOs, available to employees in 1984. Still, the indemnity plan offered by Blue Cross & Blue Shield was the dominant plan chosen. Of the 90,000 employees eligible for state-provided insurance in 1987, 64,000, or 71 percent, were enrolled in the Blue Cross & Blue Shield Key Care indemnity plan.*
>
> *In September 1987, Blue Cross & Blue Shield notified state officials of its intention to cancel the Key Care plan on October 15, 1987. This led to a decision by state policymakers to self-fund the healthcare program under the name Kentucky Kare.*

As part of extensive changes to health insurance laws adopted in HB 250, the 1994 General Assembly established the Kentucky Health Purchasing Alliance (Health Purchasing Alliance), which became effective for Commonwealth Group members effective July 1, 1995. Under the Health Purchasing Alliance, from mid 1995 through 1998, Commonwealth Group members had a choice of five Kentucky Kare options. Additionally, Commonwealth Group members could also choose one of four HMO options, four POS options, or five PPO options all through several insurance carriers.

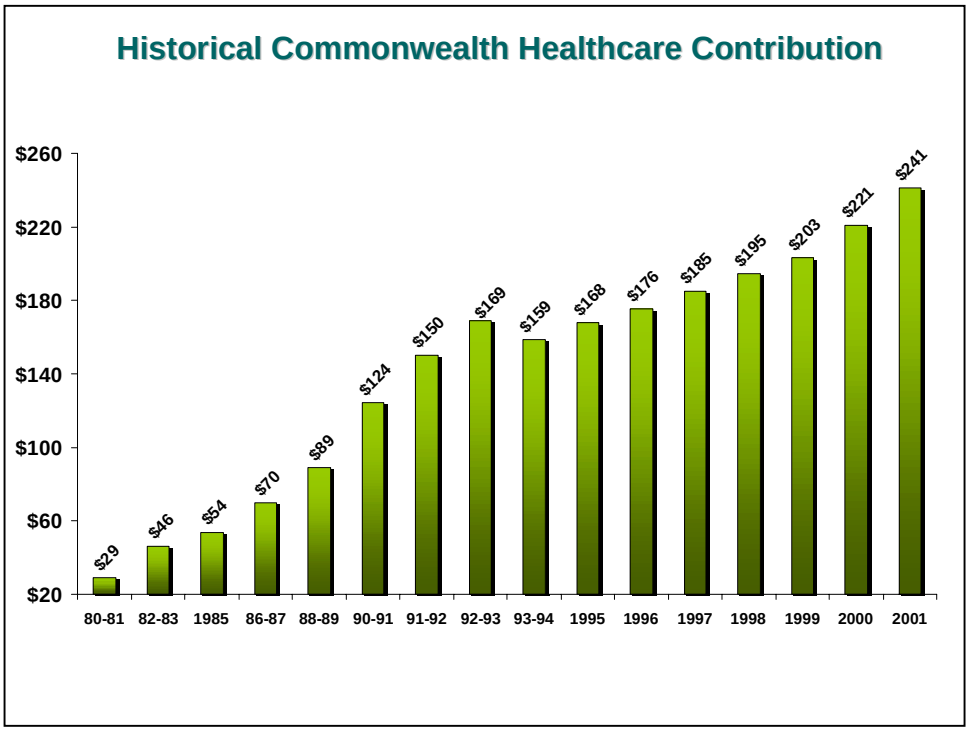
Due to mounting losses under Kentucky Kare as a result of adverse selection from diminishing enrollment, among other things, the 1998 General Assembly enacted House Bill 315, which dissolved the Health Purchasing Alliance effective December 31, 1998. This led to the Commonwealth re-establishing an independent healthcare program, the Commonwealth Public Employee Health Insurance Program, for Commonwealth Group members.

In 1999, the program offered two HMO options (A and B), two POS options (A and B) and two PPO options (A and B) through insured arrangements with seven insurance carriers (Advantage Care, Aetna, Anthem, Bluegrass Family Health, CHA Health, Humana, and Pacificare). Two indemnity plan options were offered to out-of-state retirees through Anthem. These options were continued in 2000, with the following primary revisions:

- An EPO Option C was added to provide an option to Commonwealth Group members with a lower employee premium contribution.
- Aetna was discontinued due to its elimination in the 2000 RFP process.
- A feature was added to all 2000 options that reduced the prescription drug co-payments members had to pay after they had paid 50 co-payments in a year for themselves and covered family members.

- Out-of-state retirees were allowed to elect any POS or PPO option offered by any of the insurance carriers insuring Commonwealth Group members as no insurance carrier was willing to insure an indemnity plan for these individuals.

From $9.75 per covered employee in 1972, the Commonwealth's contribution has grown to an average of $241 in 2001. The Commonwealth's per employee contribution from the 1980-1981 plan year through 2001 is reflected in the following chart.



Source: OPEHI

The remainder of this report addresses the Commonwealth's Public Employee Health Insurance Program from 1999 through 2001.

Commonwealth Public Employee Health Insurance Program

The Commonwealth Public Employee Health Insurance Program, whose members are referred to as the Commonwealth Group, became independent from the former Health Purchasing Alliance effective January 1, 1999. Therefore, the 1999 Plan Year, January 1, 1999 through December 31, 1999, forms the baseline for determining trends for the Commonwealth Group. This section of the report provides a summary of the trends identified from claims and enrollment data submitted by the insurance carriers who provide healthcare coverage to individuals who participate in the Commonwealth's Public Employee Health Insurance Program as compiled by the Office of Public Employee Health Insurance (OPEHI).

Cost, Enrollment and Utilization Data for Calendar Years 1999 and 2000

Key measures for the Commonwealth's 2000 Plan Year, in comparison to the 1999 baseline year, are provided in Exhibit I below.

Exhibit I

	Commonwealth Group 1999 and 2000 Experience Summary		
	1999	2000	% Change
Medical Claims	$323,427,312	$354,332,101	9.6%
Rx Claims	$71,389,424	$83,740,516	17.3%
Total	$394,816,736	$438,072,617	11.0%
Premiums Paid	$449,516,503	$513,829,374	14.3%
Covered Lives*	227,955	226,900	(.5%)
Per Covered Life			
Medical Claims	$118.24	$130.14	10.1%
Rx Claims	$26.10	$30.76	17.9%
Total Claims	$144.34	$160.90	11.5%
Premiums Paid	$164.33	$188.71	14.8%
Loss Ratio[5]	87.8%	85.3%	

Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI.
** See Exhibit II, page 10 and Exhibit III, page 11 for more detail.*

In aggregate, the Commonwealth's health insurance carriers issued payments to medical providers, other than pharmacies, of roughly $354 million for services received by Commonwealth Group members in calendar year 2000. This represents an aggregate increase of 9.6% over calendar year 1999. Consistent with marketplace trends, payments for prescription drugs increased by 17.3%, in aggregate, from $71.4 million in 1999 to $83.7 million in 2000. Because prescription drug expenditures increased at a much higher rate than other healthcare

[5] *Total Claims divided by Premiums Paid*

expenses, pharmacy service expenditures grew as a percentage of the Commonwealth's total healthcare expenditures from 18.1% in 1999 to 19.1% in 2000.

Total healthcare claims incurred in calendar year 2000 increased, in aggregate, by 11% from 1999 to 2000. In 2000, these expenditures totaled a little over $438 million.

While claim payments to medical providers form the majority of a health plan's expenditures, every health plan, whether insured or self-funded, incurs operating expenses for claims payment, network management, care management and associated services. All of the Commonwealth's Public Employee Health Insurance Program's offerings were insured in both calendar years 1999 and 2000. Therefore, total expenditures by the Commonwealth and individuals participating in the Commonwealth Group are reflected in the premiums paid to the insurance carriers bearing the risk for the program. In calendar year 2000, these premium payments totaled roughly $513.8 million. This reflected an increase from 1999 of 14.3%. As premiums increased at a faster pace than payments for medical supplies and services, the loss ratio (incurred claims divided by premiums) decreased from 87.8% in 1999 to 85.3% in 2000. In other words, while 12.2% of premiums was retained by the Commonwealth's health insurance carriers in 1999, 14.7% of premiums was retained in 2000 for operating expenses and/or profit. This could be a result of any or all of the following:

- higher operating expenses within the Commonwealth's insurance carriers;
- a desire for higher profits from its carriers;
- insurance carriers' propensity to use conservative trends in projecting healthcare costs for groups they insure, particularly in a period of increasing trends;
- and/or conservative projections by the Commonwealth's insurers due to the segmentation of the Commonwealth Group's risk pool among up to three carriers per county.

While the figures provided above reflect changes in aggregate expenditures year over year, it is also important to consider changes in the number of covered lives. The number of employees/retirees insured under the Commonwealth's health insurance program increased 1.5% in 2000. However, due to a decline in individuals electing dependent healthcare coverage, the number of covered lives insured under the Commonwealth's program declined ½ of one percent in 2000. Therefore, as reflected in Exhibit I, healthcare claims per covered life increased 11.5% from $144.34 in 1999 to $160.90 in 2000. While Commonwealth Group claims increased at a faster pace than the national average of 8.1%, the increase from 2000 over 1999 was in line with that of South region employers, whose healthcare program expenses grew 11.1%[6].

Enrollment Analysis

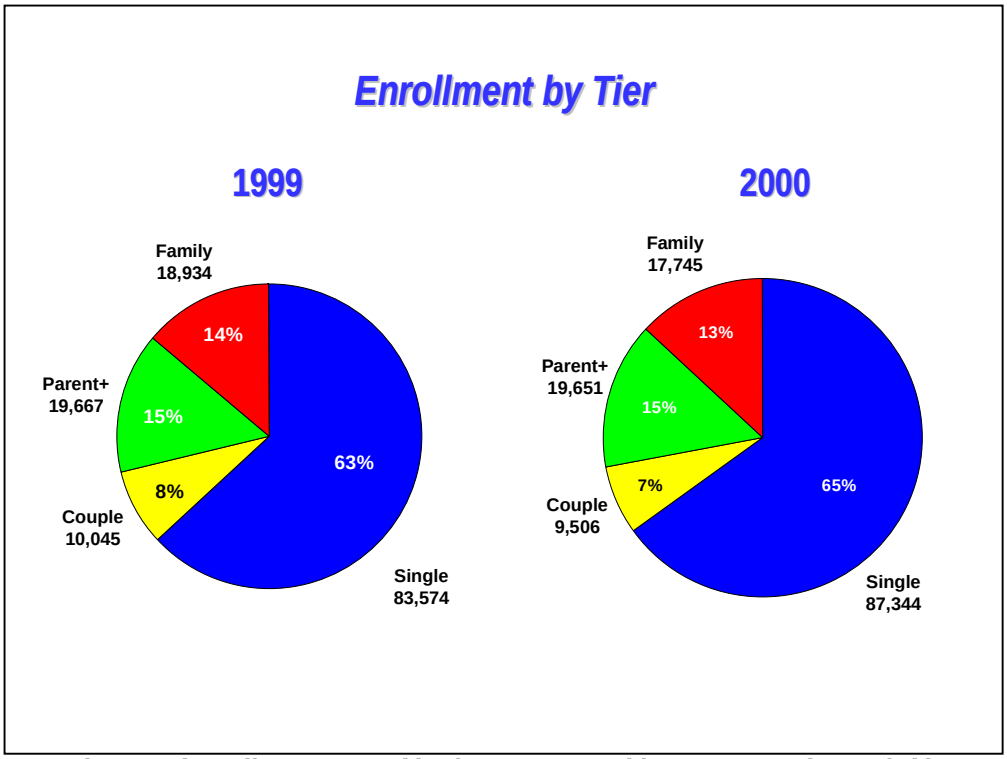
While the number of employees/retirees electing health insurance increased on average from 132,220 to 134,245 from 1999 to 2000, the average number of covered lives decreased from 227,955 to 226,900 or ½ of 1%. As illustrated by the charts in Exhibit II, this decrease in covered lives was a result of a decline in the number of individuals electing coverage for their dependents. In 1999, on average, 18,934 employees/retirees elected family coverage (coverage for a spouse and one or more children). In 2000, this decreased to 17,745. In 1999, 10,045 employees/retirees elected couple coverage (coverage for themselves and a spouse) on average.

[6] *Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans 2000*

This declined to 9,506 in 2000. The number of individuals electing parent + coverage (coverage for the employee/retiree and one or more children) remained basically constant at around 19,650.

Employee premium contributions for Parent+ coverage, at the low end, decreased $6 per month from 1999 to 2000. At the high end, employee contributions for Parent+ coverage increased $75 per month. Employee premium contributions for Couple coverage increased from a low of $5 to a high of $118 per month from 1999 to 2000, based on the healthcare option an employee elected. For Family coverage, the increase in employee contributions ranged from $9 to $132 per month.

Exhibit II



Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI.

The increase in covered employees/retirees coupled with the decline in individuals electing family and couple coverage resulted in a shift in the percentage of Commonwealth Group members with single coverage from 63% in 1999 to 65% in 2000. The decline in couple and family coverage was likely the result of two factors:

- the lack of explicit dependent subsidies in the Commonwealth's program, and
- the magnitude of premium increases resulting in employee contribution increases for dependent coverage in 2000.

Enrollment by Group

The composition of the individuals enrolled in the Commonwealth's Public Employee Health Insurance Program changed, not only with respect to the number of dependents covered under the program, but also with regard to the key sub groups that comprise the group in total. As illustrated in Exhibit III, the number of insured individuals actively employed by state agencies, school boards, and health departments declined from 1999 to 2000. However, the number of individuals insured through the Kentucky Retirement Systems (KRS) and the Kentucky Teachers Retirement System (KTRS) increased measurably from 1999 to 2000. While these two groups comprised 14.2% of the total insured Commonwealth Group in 1999, they comprised 15.4% of the group in 2000. As healthcare expenses generally increase with age, this trend has long term cost implications for the Commonwealth's Public Employee Health Insurance Program.

Exhibit III

	Average Covered Lives by Sub Group 2000 Over 1999				
	1999		2000		% Change
	Average Lives	% of Total	Average Lives	% of Total	
State Employees	62,858	27.6%	62,245	27.4%	(1.0%)
School Boards	125,100	54.9%	121,951	53.8%	(2.5%)
Health Departments	4,529	2.0%	4,234	1.9%	(6.5%)
KRS	18,041	7.9%	19,858	8.8%	10.1%
KTRS	14,388	6.3%	15,046	6.6%	4.6%
KCTCS[7]	1,787	0.8%	2,325	1.0%	30.1%
COBRA[8]	1,252	0.5%	1,241	0.5%	(0.9%)
Total	227,955		226,900		(0.5%)

Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI.

The number of individuals electing COBRA coverage remained relatively constant at around 1,250 individuals in 1999 and 2000.

Enrollment by Plan Type

The Commonwealth's Public Employee Health Insurance Program offers four different types of plans:

- Health Maintenance Organization (HMO) – These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Participants in these plans must select a primary care physician to coordinate their care. For the majority of the services covered by the HMO, participants pay a specified dollar amount (co-payment) at the time services are received.

[7] *Kentucky Community and Technical College System (KCTCS) employees hired after its separation from the University of Kentucky have only been eligible to join the Commonwealth Group. Those hired prior to the separation were allowed to choose between the Commonwealth's program and UK's health program. Therefore, KCTCS insured individuals increased significantly from 1999 to 2000.*

[8] *Title XXII of the Public Health Service Act requires state government employers to provide individuals the opportunity to continue health care coverage under a group health plan for a period of time in certain circumstances where coverage would otherwise be terminated. Individuals who exercise this option are termed COBRA beneficiaries.*

- Point of service (POS) - These plans mimic the benefits of the HMO options, provided an individual receives services from a healthcare provider that has contracted with the health plan and services are coordinated through the primary care physician designated by the individual. Unlike the HMO options, the POS options provide coverage for services received from a provider that is not in the health plan's network, at a higher cost sharing percentage to the insured.
- Preferred Provider Organization (PPO) – These plans require lesser cost sharing from participants, if covered services are received from a healthcare provider that participates in the health plan's network. Coverage is provided for services received from a provider that is not in the health plan's network, with participants paying a larger proportion of the cost of covered services. Unlike POS plans, PPOs do not require referrals from a participant's primary care physician. The PPOs offered under the Commonwealth's Public Employee Health Insurance Program provide the same benefits for services received in a network physician's office and for prescription drugs as do the HMO and POS options. However, for services received in a network hospital or surgical center, PPO participants pay a percentage of the cost of services received (co-insurance) after paying an annual deductible, rather than a specified dollar co-payment. The amount of co-insurance that a participant pays annually is capped by the PPO plan's out-of-pocket limit.
- Exclusive Provider Option (EPO) – These plans require services to be received from a healthcare provider that participates in the health plan's network in order for the service to be covered by the plan. Depending on the insurance carrier chosen, the participant may or may not have to designate a primary care physician to coordinate his/her care. Beginning January 1, 2000, the EPO was added to provide a lower premium cost option to participants.

For each HMO, POS and PPO offered under the Commonwealth's Public Employee Health Insurance Program, there are A and B options. The A options require lesser participant cost sharing at the time services are received, but have higher premiums. The B options require higher participant cost sharing when healthcare services are received and have lower premiums. There is only one EPO option, Option C. This option is offered by every insurance carrier that participates in the Commonwealth's Public Employee Health Insurance Program. (A summary of the key provisions of Commonwealth Group options for 2001 is provided in Appendix D.)

In 2000, HMO enrollment remained constant with 1999 at 51% of the group. POS enrollment declined dramatically from 1999 to 2000 from 33% to 28%. The POS options are the most expensive options the Commonwealth offers in areas where a choice of plan types is available, so it is likely that premium cost increases were a factor in the POS enrollment decline.

The decline in POS enrollment was offset by an increase in PPO Option A enrollment, and the new EPO option C implemented January 1, 2000. Interestingly, other than the enrollment in the EPO option, there was virtually no shift in enrollment from the higher priced A options to the lower cost B options.

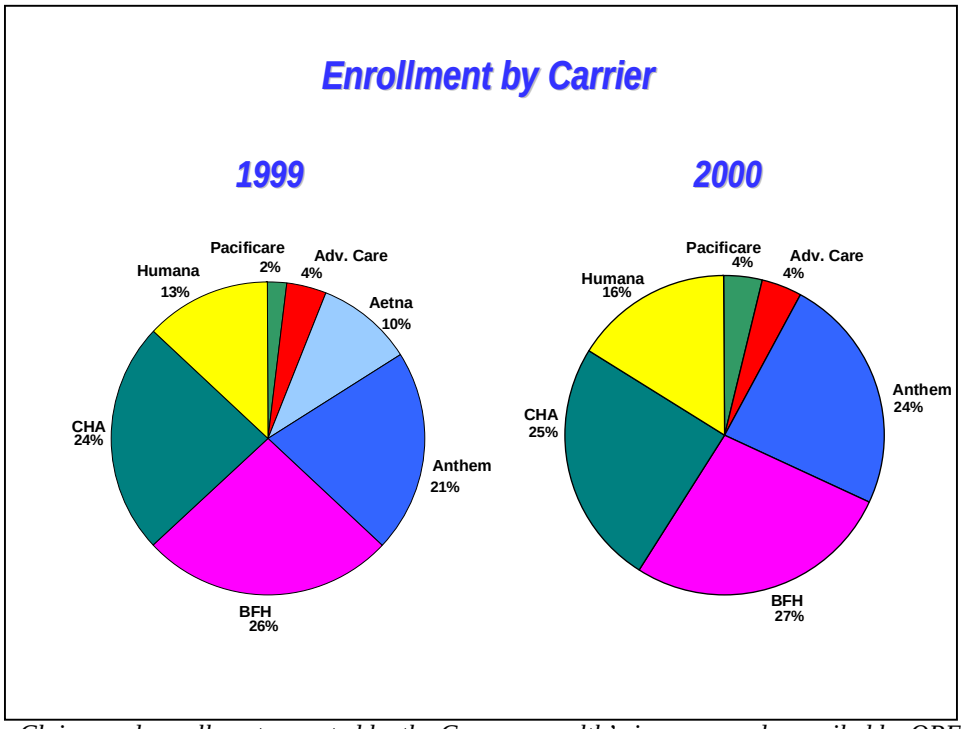
Enrollment by Carrier

The primary change in enrollment by insurance carrier from 1999 to 2000 resulted from the elimination of Aetna during the 2000 RFP process. In 1999, 10% of insured Commonwealth Group members were enrolled in an Aetna healthcare option. The majority of individuals enrolled in an Aetna healthcare option in 1999 moved to either an Anthem, Humana or Pacificare option in 2000 as these carriers have coverage available in some or all of the same service areas

in which Aetna provided coverage in 1999. However, the percentage of individuals enrolled in CHA and Bluegrass Family Health (BFH) increased by 1 percentage point from 1999 to 2000 as well. The charts in Exhibit IV below contrast the percentage of Commonwealth Group members enrolled in each carrier's offerings in 1999 and 2000.

Exhibit IV

.



Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI

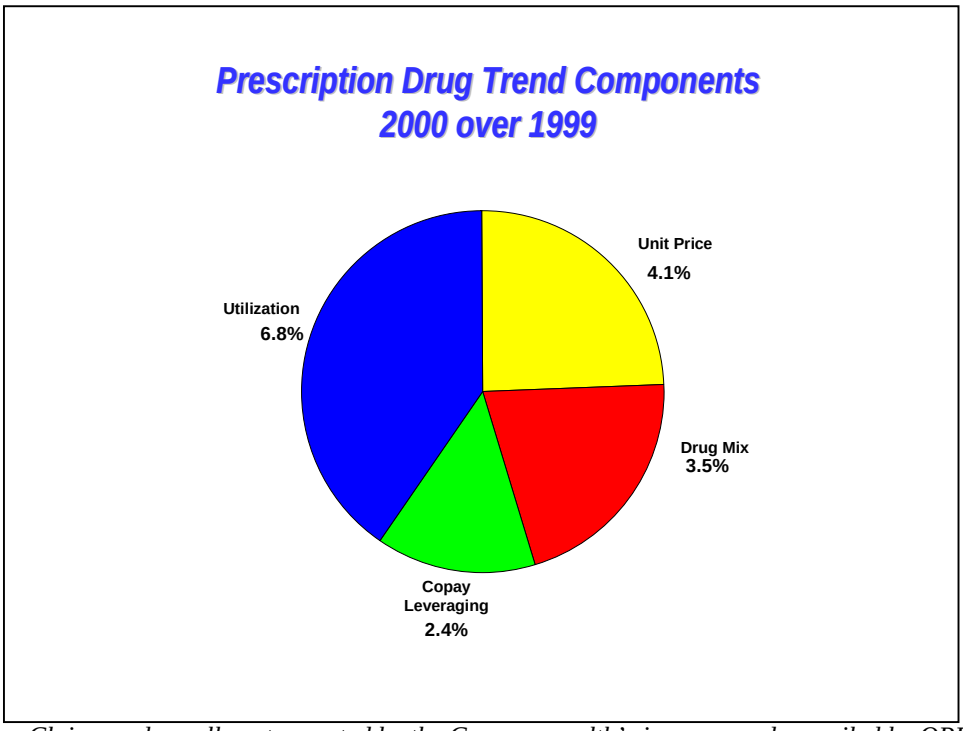
Prescription Drug Coverage

Consistent with marketplace trends, increases in prescription drug expenditures under the Commonwealth's Public Employee Health Insurance Program out paced cost increases for other covered services. This increase is attributable to four identifiable factors:

- an increase in unit price per prescription for the same drug (*Unit Price*),
- a change in the mix of drugs received by Commonwealth Group members (*Drug Mix*),
- co-payment leveraging – the impact of fixed dollar co-payments on a health plan's cost in relation to unit price increases (*Copay Leveraging*), and
- an increase in the number of prescriptions received (*Utilization*).

Unit Price - As illustrated in Exhibit V which follows, unit price, as measured by comparing the price per prescription for the top 100 drugs utilized by Commonwealth Group members in 2000 with the price of the same drug in 1999, increased 4.1% from 1999 to 2000. This component of the Commonwealth's prescription drug expenditure increase is limited to the pure price increase that would have resulted if covered individuals received exactly the same drugs in 2000 as were received in 1999.

Exhibit V



Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI.

Drug Mix - Over time, physicians' prescribing patterns and patients' preferences for certain prescription drugs change. Since 1997, this has been dramatically affected by three factors:

1) "direct-to-consumer" advertising by the pharmaceutical industry;
2) increases in the number of pharmaceutical representatives employed to detail physicians; and
3) an influx of new drugs into the marketplace.

For example, Naproxen and Celebrex are two drugs that physicians prescribe to help alleviate the pain of arthritis. Suppose a Commonwealth Group member took Naproxen in 1999 and in 2000, and the cost per prescription for Naproxen increased from $11.00 to $11.44, or 4%. This price increase would be reflected in the *Unit Price* change previously discussed. However, if this same patient changed from Naproxen at a cost of $11.00 per prescription in 1999 to Celebrex in 2000 at a cost of $83.00, the cost per prescription would have increased 655%. The additional 651% change in the cost per prescription, above the cost increase that would have occurred had the participant continued to take Naproxen, was due to a change in *Drug Mix*.

To measure the aggregate impact that changes in the mix of prescriptions that Commonwealth Group members received had on the program's pharmacy costs, the average cost per prescription for 1999 was compared to 2000. After eliminating the change in pharmacy costs due to *Unit Price* increases (4.1%), the resulting increase in the cost per prescription from 1999 to 2000, due to the change in the mix of drugs received, was 3.5%.

Copay Leveraging - When prescriptions are received from a network pharmacy, members of the Commonwealth Group pay a fixed dollar co-payment for each prescription. These co-payments have remained the same or declined since 1999. Due to the fact that the amount members paid for prescriptions remained constant while the cost per prescription increased, the amount paid by

the Commonwealth's Public Employee Health Insurance Program, per prescription, increased in 2000 at a higher rate than the total cost per prescription. This impact is illustrated by the following example:

- A brand name prescription cost $50 in 1999.
- The patient who received this prescription was covered under the HMO A option offered by the Commonwealth, resulting in a patient co-payment of $15, and a resulting cost to the health plan of $35.
- In 2000, this same patient received the same prescription, but at a cost of $53.75, an increase of 7.5%. The member's co-payment remained at $15, resulting in a cost to the health plan of $38.75.
- While the cost per prescription increased 7.5% ($3.75/$50), the increase in cost to the Commonwealth Group was 10.7%, derived by dividing the increase of $3.75 by the plan's payment of $35 in 1999.

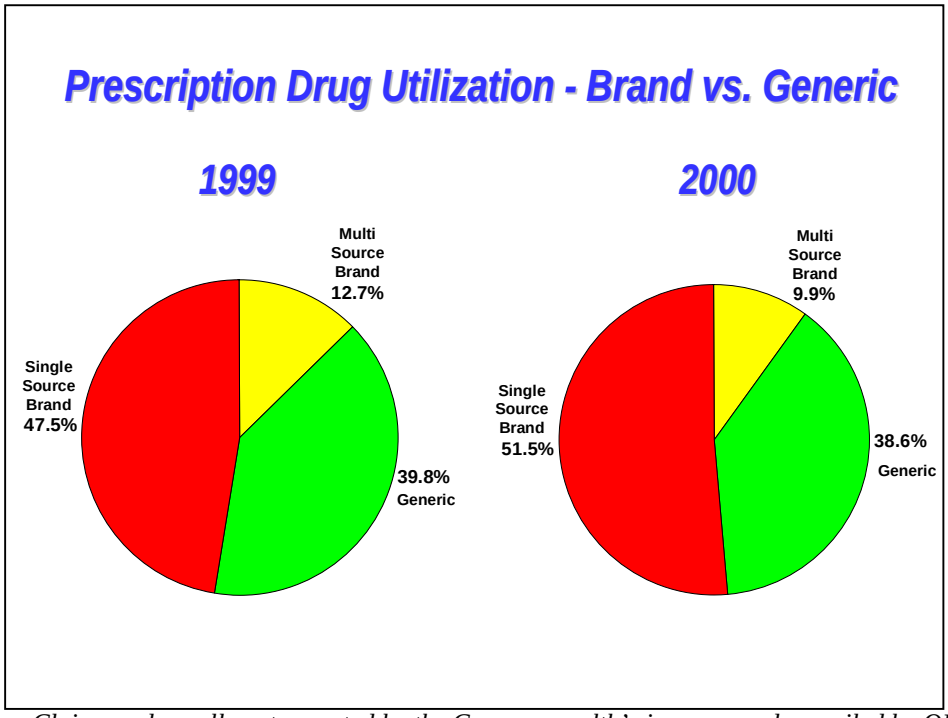
In 2000, the leveraging resulting from the fixed dollar prescription drug co-payments in the Commonwealth's Public Employee Health Insurance Program resulted in an increase in prescription drug costs of 2.4% or $1.7 million dollars. (Fixed dollar co-payments for physician office visits had a similar impact. To a lesser extent, this is also true of fixed dollar co-payments for inpatient and outpatient hospital services. Overall, it is estimated that fixed dollar co-payments added over $3 million in increased cost to the Commonwealth's Public Employee Health Insurance Program.

Utilization - The final component of the Commonwealth Group's prescription drug expenditure increase from 1999 to 2000 was due to an increase in the number of prescriptions that were received by its members. The number of prescriptions paid for by the Commonwealth's Public Employee Health Insurance Program increased 6.8% from 1999 to 2000.

The number of single-source brand name drugs received by Commonwealth Group members increased at the fastest pace, 15.6%, to almost 1.6 million prescriptions. These drugs, for which no generic drug is available, are typically the most expensive prescription drugs. The number of multi-source brand prescriptions, those drugs for which an alternative drug is available, decreased 17%. The number of generic prescriptions, the least expensive type of prescription, increased, but by a much lower rate (3.7%) than single-source brand drugs.

As illustrated in Exhibit VI, due to the unequal increase in utilization by type of prescription, the percentage of prescriptions received by Commonwealth Group members dispensed as single source brand name drugs grew from 47.5% to 51.5% in 2000. Multi-source brand name drugs declined from 12.7% of all prescriptions received to 9.9%. The generic prescription percentage also declined from 39.8% to 38.6%. This trend is consistent with the experience reported by large pharmacy benefit managers in other employers' health plans.

Exhibit VI



Source: Claims and enrollment reported by the Commonwealth's insurers and compiled by OPEHI.

Legislative Impact

Statutory health insurance mandates enacted by the Commonwealth of Kentucky's General Assembly affect the Commonwealth's Public Employee Health Insurance Program, as well as other employers' health insurance programs. Historically, the two most significant pieces of legislation impacting the Commonwealth's employee/retiree health insurance program were:

- House Bill 250, enacted by the 1994 General Assembly, which established the Health Purchasing Alliance that Commonwealth Group members and their dependents participated in from 1995 through 1998, and
- House Bill 315, enacted by the 1998 General Assembly, which revised the health insurance reforms enacted in 1994 and 1996, including the provision to dissolve the Health Purchasing Alliance.

In its 1998 and 2000 sessions, the General Assembly enacted several statutory mandates that apply to health insurance programs. A brief outline of the mandates enacted in 1998 and 2000, that applied to the Commonwealth's Public Employee Health Insurance Program effective on or after January 1, 1999 when the Personnel Cabinet assumed responsibility for the program, is provided in the following chart.

Exhibit VII

1998 and 2000 General Assembly Health Insurance Mandates *Chart reflects legislation effective on or after January 1, 1999*			
Year Enacted	**Bill**	**Impacted Commonwealth Group**	**Key Provisions**
1998	HB 315	✔	Health Insurance Reform
1998	HB 380	Covered Benefit	Coverage of diabetes services and supplies
1998	HB 618	Covered Benefit	Cancer drug coverage
1998	HB 864	Covered Benefit	Women's health ▪ breast reconstruction following mastectomy ▪ endometriosis and endometriatis treatment ▪ bone density testing
1998	SB 63	✔	Autism respite and rehabilitative care – $500 per month maximum – children 2 to 21
1998	SB 135	✔	▪ Cochlear implants ▪ Provider directory distribution
2000	HB 9	Covered Benefit	Mammography coverage
2000	HB 177	Covered Benefit	Telehealth services
2000	HB 202	✔	▪ Newborn coverage from moment of birth ▪ Treatment of inherited metabolic diseases including amino acid preparations and low-protein modified food products
2000	HB 268	✔	Mental Health Parity
2000	HB 281	Covered Benefit	Registered nurse first assistants covered
2000	HB 390	✔	▪ Utilization review rules ▪ Independent external review
2000	HB 757	✔	▪ Hold harmless and continuity of care upon contract termination ▪ Drug formulary summary required at enrollment ▪ Network access requirements modified ▪ Prudent lay person standard for emergency services
2000	SB 279	✔	Prompt payment of medical claims
2000	SB 335	✔	Coverage of certified surgical assistants

Compiled by the Office of Public Employee Health Insurance and modified by William M. Mercer, Incorporated for this report

Many of these mandates have not impacted the Commonwealth Group as the services mandated were already covered by the health insurance options offered to the group (designated above with "Covered Benefit" in the column labeled Impacted Commonwealth Group). However, Senate Bill 63, enacted in 1998, impacted the Commonwealth's Public Employee Health Insurance Program as it extended coverage of the care of autistic children to include respite services. This requirement is somewhat unique, as health insurance programs rarely cover custodial type care, such as respite care, other than for terminally ill patients under hospice provisions. Senate Bill 135, also enacted in 1998, expanded covered services under the Commonwealth's Public

Employee Health Insurance Program to include cochlear implants as did HB 268, enacted in 2000, which eliminated the mental health inpatient hospital day and outpatient visit limits previously present in the Commonwealth's healthcare options.

Statutory mandates enacted by the 1998 and 2000 General Assemblies have not substantially impacted the Commonwealth's healthcare program's costs. However, some existing statutes may adversely impact the Commonwealth Group.

Model Procurement

Although the model procurement code operates well for other Commonwealth purchases, its application to the purchase of health insurance may create unintended consequences. For example, if the Commonwealth needs additional carriers in certain areas, and, during negotiations, an insurance carrier is otherwise willing to expand its proposal to include those areas, the carrier cannot adjust its bid to account for the risks and costs of these areas. Consequently, the opportunity to add plan choices in under served areas may be rebuffed by carriers. The Office of Public Employee Health Insurance (OPEHI) and the Department of Administration are working jointly to study this issue.

Retirees in Commonwealth Group without Corresponding Actives

KRS 61.702 stipulates that the Kentucky Retirement Systems shall arrange for health insurance for any individual receiving a retirement allowance from the Kentucky Employees Retirement System (KERS), County Employees Retirement System (CERS), and State Police Retirement System (SPRS). This includes individuals who retire from municipalities and cities across the Commonwealth. It also includes individuals who retire from public regional universities within the Commonwealth. Furthermore, the Retirement Systems' board may authorize these individuals "to be included in the state employees' group" for health insurance. No corresponding statutory provision requires active employees of these employers to participate in the Commonwealth's Public Employee Health Insurance Program.

Although it appears that HB 250 intended for active employees of cities, municipalities and regional universities to be included in the Commonwealth Group as a part of the Health Purchasing Alliance, these groups either never joined the Purchasing Alliance or established health insurance programs separate from the Commonwealth's Public Employee Health Insurance Program when the Purchasing Alliance was disbanded. At this time, there are a number of retirees who participate in the Commonwealth Group for whom the corresponding active employee group does not. A list of the entities whose retirees are allowed to participate in the Commonwealth Group but whose active employees do not is provided in Appendix B. This list also provides the total number of actives and retirees of each entity.[9]

As healthcare costs generally increase as an individual ages, the inclusion of retirees without the corresponding active group raises the average cost per covered life in the Commonwealth's Public Employee Health Insurance Program for both the Commonwealth and Commonwealth Group members. Further information regarding the impact this has on the Commonwealth Group can be found in the Adverse Selection section of this report.

[9] *Source: Kentucky Retirement Systems*

Double Dippers

KRS 18A.227(4) precludes any individual employed under KRS Chapter 16, KRS Chapter 18A, or KRS Chapter 151B from receiving the state healthcare contribution as an active employee if the individual is also eligible for and elects to participate in the Commonwealth's Public Employee Health Insurance Program as a retiree, or the spouse of a retiree, under any of the Kentucky Retirement Systems. However, there are still individuals who receive more than one state healthcare contribution, referred to as "double dippers".

Flexible Spending Account (FSA) Forfeitures

The Commonwealth currently funds a healthcare flexible spending account (FSA), equal to $234 per month, for every active employee who waives healthcare coverage through the Commonwealth Group. As of February 2001, there were about 27,750 active employees of the Commonwealth Group waiving healthcare coverage through the Commonwealth's Public Employee Health Insurance Program, resulting in annual Commonwealth-funded FSA contributions of around $77.9 million. Under federal law, any funds remaining in a participant's FSA, after all eligible expenses for the Plan Year have been reimbursed, are forfeited.

While the amount of FSA forfeitures attributable to the Commonwealth's FSA waiver contribution is not known for the Commonwealth Group, for 1999, active employees of state agencies forfeited around 22% of the total funds contributed to their FSAs from the state's contribution and their own contributions. In 2000, this forfeiture rate was 24%.[10] Applying these percentages to the estimated total Commonwealth-funded FSA contributions for 2001 results in projected forfeitures of roughly $17 to $19 million.

KRS 18A.225(2)(g) specifies that "any funds in flexible spending accounts that remain after all reimbursements have been processed shall be transferred to the credit of the state health insurance plan's appropriation account". However, during budget discussions, the application of this provision to school boards, the largest segment of the Commonwealth Group, was overridden. This override allows a substantial amount of Commonwealth funds to be used at the discretion of the employing entity.

Prior Bills

Additionally, some bills that have been introduced in the past could have had a significant impact on the Commonwealth Group had they been enacted. These include:

- those that would allow individuals who are not Commonwealth employees or retirees or employees of groups that participate in a Commonwealth sponsored retirement program to join the Commonwealth Group;
- those that would allow the Commonwealth's insurance carriers to charge different rates in different areas of the state; and
- those that would preclude the Commonwealth from restricting the number of carrier choices offered in a given geographic area.

The Adverse Selection section of this report provides further discussion about the impact provisions of this nature would have on the Commonwealth's Public Employee Health Insurance Program.

[10] *Personnel Cabinet*

Input from Advisory Committee of State Health Insurance Subscribers

Quarterly, the OPEHI meets with the Advisory Committee of State Health Insurance Subscribers (referred to as the Employee Advisory Committee (EAC)) specified by KRS 18A.225 (12) to review information regarding the Commonwealth's Public Employee Health Insurance Program and to obtain input regarding the program. The chair of this committee is a member of the Group Health Insurance Board, established by KRS 18A.226. A list of the members of this committee for 2001 is provided in Appendix E.

In a letter to Carol Palmore dated June 25, 2001, Chairperson of Kentucky Group Health Insurance Board, the Advisory Committee submitted the following recommendations (excerpted as written) with respect to the Commonwealth's Public Employee Health Insurance Program for the Board's consideration:

- Pay full cost of lowest single coverage Option A.
- When establishing funding, include anticipated increases in healthcare costs to maintain current level of health insurance provision.
- Subsidize the cost of dependent coverage, without impacting the ability to provide single coverage (lowest Option A) at no contribution.
- Provide same treatment of all groups with the goal to eliminate double-dippers.
- Preserve integrity of group to protect its financial status.
- Expand the Board to include a broader group of stakeholders.

Findings

- In 2000, Commonwealth Group healthcare claims increased at a faster pace than the national average of 8.1%. However, the increase was in line with that of South region employers, whose healthcare program expenses grew 11.1%.
- Overall healthcare claims for the Commonwealth Group increased 11.5% per covered life from 1999 to 2000. However, prescription drug expenditures in the Commonwealth's Public Employee Health Insurance Program grew 17.9%.
- An in-depth analysis of the Commonwealth Group's prescription drug experience in 1999 and 2000 indicates that costs within the Commonwealth's Public Employee Health Insurance Program are increasing due to several factors:
  - an increase in unit price for the same prescription drug of roughly 4.1%,
  - a change in the mix of prescription drugs received by Commonwealth Group members of about 3.5%,
  - co-payment leveraging – the impact of fixed dollar co-payments on a health plan's cost in relation to unit price increases of 2.4%, and
  - an increase in the number of prescriptions received by Commonwealth Group members of 6.8%.
- Health insurance premiums increased at a higher rate in 2000 (14.8%) than the actual claims paid to healthcare providers for services received by Commonwealth Group members (11.5%). Potentially, this may be a result of:
  - higher operating expenses within the Commonwealth's insurance carriers;

- a desire for higher profits from its carriers;
- insurance carriers' propensity to use conservative trends in projecting healthcare costs for groups they insure, particularly in a period of increasing trends;
- and/or conservative projections by the Commonwealth's insurers due to the segmentation of the Commonwealth Group's risk pool among up to three carriers per county.

- Without dependent subsidies, Commonwealth Group members will be faced with increasingly higher contributions for dependent healthcare coverage. As occurred in 2000, this may result in a continual decline in the number of employees/retirees electing dependent healthcare coverage through the Commonwealth's Public Employee Health Insurance Program. However, the Employee Advisory Committee does not want dependent subsidies, if the Commonwealth should choose to fund any portion of the cost to do so by modifying its policy of paying the full cost of single coverage under the lowest cost Option A available in each county.
- Fixed dollar co-payments in the Commonwealth's Public Employee Health Insurance Program's options result in health plan cost increases that exceed the increase in the cost of services received. In 2000, it is estimated that leveraging from fixed dollar co-payments added over $3 million in increased cost to the Commonwealth's Public Employee Health Insurance Program. However, consistent with input from the Employee Advisory Committee, the Board's consensus is to maintain the current level of benefits, to the extent possible.
- The growth of covered retirees as a percentage of the Commonwealth Group will present a challenge to efforts to maintain affordable healthcare benefits in a period of escalating healthcare costs. This is compounded by the inclusion of CERS and regional university retirees for whom the corresponding active groups do not participate in the Commonwealth's Public Employee Health Insurance Program. This topic is discussed in more detail in the Adverse Selection section of this report.
- While KRS 18A.227(4) precludes many Commonwealth Group members from receiving two state healthcare contributions – one as an active employee and one as a retiree – there are still individuals who receive more than one state healthcare contribution.
- Forfeitures from Commonwealth funds contributed to healthcare flexible spending accounts of Commonwealth Group members who waive health insurance coverage through the group could amount to $17 to $19 million in 2001. While KRS 18A.225(2)(g) provides that these forfeitures shall be transferred to the credit of the state health insurance plan's appropriation account, the current budget overrides the application of KRS 18A.225(2)(g) with respect to school boards, the largest segment of the Commonwealth Group.
- Although the model procurement code operates well for other Commonwealth purchases, its application to the purchase of health insurance may create unintended consequences. For example, if the Commonwealth needs additional carriers in certain areas, and, during negotiations, an insurance carrier is willing to expand its proposal to include those areas, the carrier cannot adjust its bid to account for the risks and costs of these areas. Consequently, the opportunity to add plan choices in under served areas may be rebuffed by carriers. The Office of Public Employee Health Insurance (OPEHI) and the Department of Administration are working jointly to study this issue.

Other State Programs

Survey Approach

To fulfill the informational requirement outlined in SB 288 regarding other states' employee healthcare programs, a survey document was compiled and distributed by the Office of Public Employee Health Insurance (OPEHI) to all other 49 states. States were informed that they would receive a summary of the survey results in exchange for their survey response. Furthermore, OPEHI personnel called every state to encourage participation in the survey.

William M. Mercer Incorporated held follow up conversations with the thirty-eight states that submitted a completed survey to clarify responses where needed. Survey responses were compiled in an Access database. To the extent available, this data was supplemented with information from the *2000 Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans* and data publicly available through the internet. In total, some data was obtained for 46 of the 49 states. Only three states are missing from the survey results in their entirety – Hawaii, Maryland, and Rhode Island.

A list of the states responding to the Commonwealth's survey is provided in Appendix A. This list also specifies the alternate data source used for any state. The data depicted in all charts and graphs in this section, for states other than the Commonwealth, was derived from the data source identified in Appendix A. Data for the Commonwealth's Public Employee Health Insurance Program was obtained from the eligibility database maintained by OPEHI and the Commonwealth's Health Insurance Handbook for 2000.

Covered Groups

Like the Commonwealth, the majority of states (92%) cover pre-65 retirees under the same healthcare program as active employees. However, about 30% of states rate pre-65 retirees separately from active employees – either through a separate program or under a consolidated active/retiree program. And, as noted under the Retiree Coverage section that follows, the majority of states apply a contribution structure that is different than the one applicable to active employees. The other groups participating in states' healthcare programs vary more as illustrated in the following table.

Exhibit VIII

	Groups Covered Under States' Employee Healthcare Programs	
	% of Other States Covering	Commonwealth Group Includes
Universities	71%	Regional retirees only
Teachers	42%	Yes
Health Boards	42%	Yes
Local Governments*	24%	▪ Retirees ▪ Actives - optional
Legislative*	8%	Yes
Quasi Government*	8%	Yes
Direct Pay*	3%	No
Contract Employees*	3%	No
Boards*	3%	No
Judicial*	3%	Yes

* These are write in responses and therefore may be understated.

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

Plan Offerings and Design Provisions

Most states offer their employees a choice of healthcare options. However, as illustrated below, the Commonwealth offers its employees more health plan choices than most states.

Exhibit IX

	Minimum, Maximum and Average Number of Health Plan Choices Offered to Each Employee Participating in a State's Healthcare Program						
	Commonwealth Group	% of Other States Offering					
		1 Choice	2 Choices	3 Choices	4 Choices	5 Choices	6 or more Choices
Minimum # of Choices	**3**	45%	32%	5%	3%	5%	10%
Maximum # of Choices	**19**	8%	11%	19%	5%	14%	43%
Average # of Choices	**5**	9%	22%	25%	16%	12%	16%

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

As shown in the row titled Minimum Number of Choices, in the Commonwealth's Public Employee Health Insurance Program, every employee/retiree has a minimum of at least three health insurance choices – at least one A option, one B option and an EPO C option. 45% of other states offer some of their employees only 1 health plan choice and an additional 32% offer some of their employees only two health plan choices. Seventy-seven percent offer at least some of their employees fewer choices than the minimum number available to every Commonwealth Group member.

The maximum number of health plan choices offered to any Commonwealth Group member in 2001 is nineteen. In comparison, 57% of other states offer fewer than 6 health plan choices to any of their employees.

On average, Commonwealth Group employees/retirees have 5 health plan choices. Nine percent of other states only offer an average of 1 health plan choice to their employees, 22% an average of 2 choices, 25% an average of 3 choices, and 16% an average of 4 choices. Like the Commonwealth, 12% of other states offer an average of five health plan choices to their employees. Only 16% of other states offer more health plan choices, on average, to their employees than the Commonwealth does.

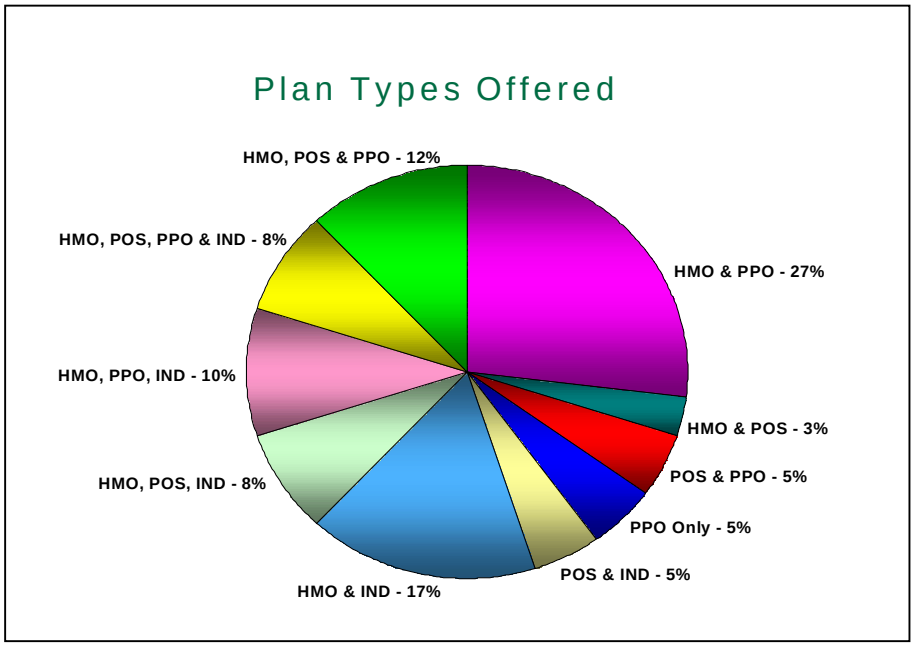
A chart is provided in Appendix C that provides the number of health plan choices offered through the Commonwealth's Public Employee Health Insurance Program in each county within the Commonwealth.

Plan Types

HMOs are the most prevalent type of healthcare option offered by other states to their employees. Of 40 states for which information was available in this regard, 85% offer HMOs. This was followed by PPOs, offered by 68% of other states. Point of Service (POS) plans are the least prevalent plan type, offered by only 40% of other states. The Commonwealth offers all three of these plan types, depending on their availability, in various areas throughout the state.

Like the Commonwealth, many other states offer more than one plan type. The most prevalent combination is HMO and PPO at 27%. The least prevalent is HMO and POS at only 3%. Twelve percent offer a combination of HMO, POS and PPO plans, like the Commonwealth.

Exhibit X



Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

The Commonwealth of Kentucky does not offer an indemnity option to its employees. However, 48% of other states reported that they offer an indemnity option to at least some faction of their employee population. Of these:

- 30% offer an indemnity option to all employees,

- 10% to only Medicare eligible retirees (For the Commonwealth, this group of individuals receives healthcare benefits under a separate arrangement managed by the retirement systems.),
- 3% to only those where no other plan is available,
- 3% to only out-of-state employees and retirees, and
- 3% to only Medicare eligible and out-of-state.

Eighty-eight percent of other states offer at least one consistent plan statewide. Most often, 54% of the time, this option is a PPO option. Next most common are indemnity plans at 30% and HMOs at 22%. A POS option is only available statewide in 17% of other states. (Note: These percentages total more than 100% as some states offer more than one plan type statewide.) Although PPO options are offered in 115 of 120 counties of the Commonwealth, the only healthcare option the Commonwealth offers statewide is the EPO C option. Employee contributions for these options, as well as the other options offered under the Commonwealth's Public Employee Health Insurance Program, vary based on the insurance carrier(s) willing to offer coverage in each county.

Plan Provisions

The key provisions of the Commonwealth's HMO and POS options are similar to those of the primary plans of other states. However, Commonwealth Group members pay co-payments for services received in a hospital setting under the HMO A option and higher co-payments for generic prescription drugs under both the HMO and POS plans. This is illustrated by the comparison of participant cost-sharing amounts for the Commonwealth's A options with the median of the primary plan reported by other states in the following chart.

Exhibit XI

	Key Provisions of Primary Healthcare Plans Offered by States					
	HMO		POS In-Network		PPO In-Network	
	Other States	KY 2001 Option A	Other States	KY 2001 Option A	Other States	KY 2001 Option A
Hospital inpatient	$0	$100	$125	$100	10%	20%
Outpatient surgery	$0	$50	$0	$50	10%	20%
Physician office	$10	$10	$10	$10	$10 or 10%	$10
Rx – retail						
Generic	$7	$10	$5	$10	$6	$10
Brand	$15	$15	$15	$15	$15	$15
Non Formulary*	$25	$30	$27.50	$30	$30	$30
Rx – mail	78% offer	not offered	65% offer	not offered	79% offer	not offered
Annual deductible**	N/A	N/A	N/A	N/A	$225	$250
Annual out-of-pocket maximum**	N/A	$1,000	$500	$1,000	$1,000	$1,250

* 44% of other states reported a 3-tier Rx co-pay for HMOs, 35% for POS, and 52% for PPOs

** individual

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

With the participant paying 20% of the cost of services received, the Commonwealth's primary PPO option is leaner than the typical primary PPO option offered by other states with respect to services that occur in a hospital or outpatient surgical center. However, the individual out-of-pocket maximum, after which the plan pays 100% of the cost of services, in the Commonwealth's PPO option A is only $250 more annually than the typical PPO in other states.

In aggregate, the actuarial value of the Commonwealth's HMO A option is around 99% of the value of the median HMO option offered by other states. The actuarial value of the Commonwealth's POS A option is within ½% of the value of the median POS option offered by other states, and the Commonwealth's PPO A option is within 6% of the value of the median PPO option offered by other states.[11]

Many healthcare programs include specific benefits for prescription drugs received from mail order pharmacies, including roughly 80% of other states' healthcare programs, as indicated in the preceding chart. When structured properly, both the health plan and its members save valuable prescription drug dollars when a mail order pharmacy feature is included. Members typically pay lower co-payments and receive the added convenience of ordering and receiving prescription drugs at their homes. For example, an employee or retiree who currently purchases 48 maintenance brand name prescriptions annually would pay $720 in prescription drug co-payments under the Commonwealth's Public Employee Health Insurance Program A options. If a mail order option were incorporated, with 90 days of medication available for 2 retail co-payments, the employee/retiree would pay only $480 in co-payments for these same prescriptions, saving $240 annually, or 33% of the cost of his/her maintenance prescriptions.

A health plan's mail order savings varies based on its underlying reimbursement arrangements for both retail and mail prescriptions, drug mix, and utilization. In general, it is estimated that a plan like the Commonwealth's could save up to 1% of prescription drug costs for every 10% of

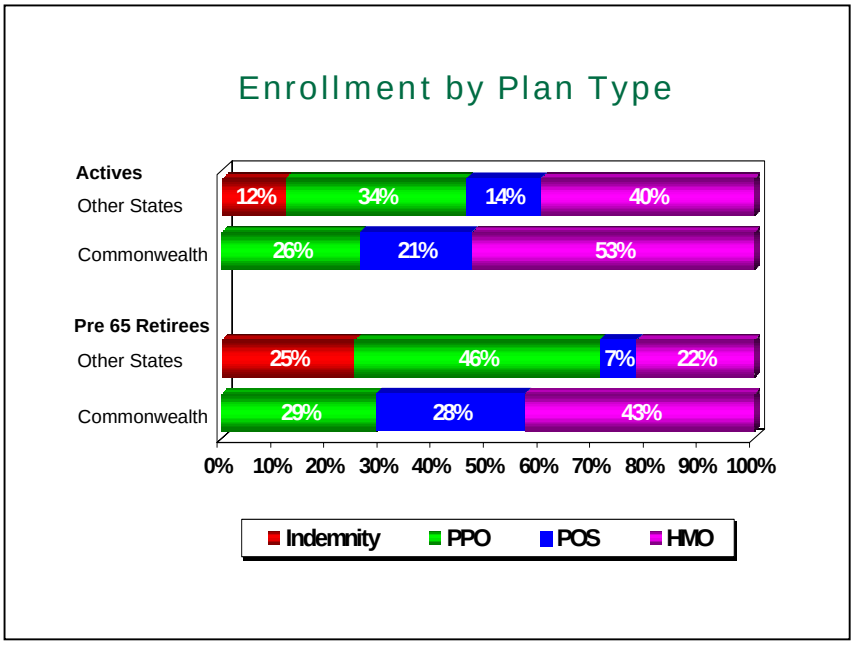
[11] *William M. Mercer, Incorporated*

prescriptions that are filled via mail, if a mail order pharmacy provision were added where the mail order co-payment for a 90-day supply of a maintenance drug is 2 times the retail co-payment for a 30-day supply of the same drug.[12]

Enrollment

Likely due to the impact of the Health Purchasing Alliance and the availability of HMOs in a wider geographic area than other states, a larger percentage of Commonwealth employees who have elected healthcare coverage through the state are enrolled in HMOs and POS options than employees in other states. This difference is even more pronounced for pre-65 retirees.

Exhibit XII



Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

Subsequently, a smaller percentage of Commonwealth employees are enrolled in PPO options than other states. Indemnity coverage is not offered by the Commonwealth. This coverage type accounts for a relatively small percentage, 12%, of other states' healthcare enrollment for active employees. It accounts for a quarter of the enrollment of other states' pre-65 retirees.

Contribution Structures and Dependent Subsidies

Unlike the Commonwealth, the majority of other states subsidize the cost of dependent healthcare coverage and require individuals to pay a portion of the cost of individual healthcare coverage premiums.

[12] *William M. Mercer, Incorporated*

Exhibit XIII

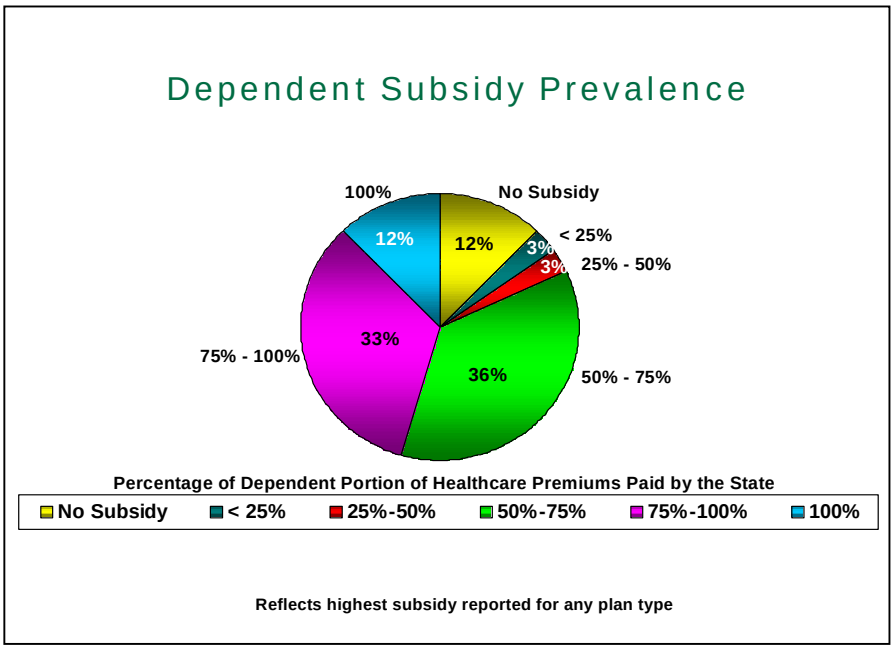
	State Healthcare Premium Subsidy	
	Individual	Dependents
State pays full cost*	38%	12%
State subsidizes cost	62%	76%
No state subsidy	–	12%

* of at least one reported plan

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

As illustrated in the following graph, most commonly, other states pay 50% or more of the dependent portion of healthcare premiums.

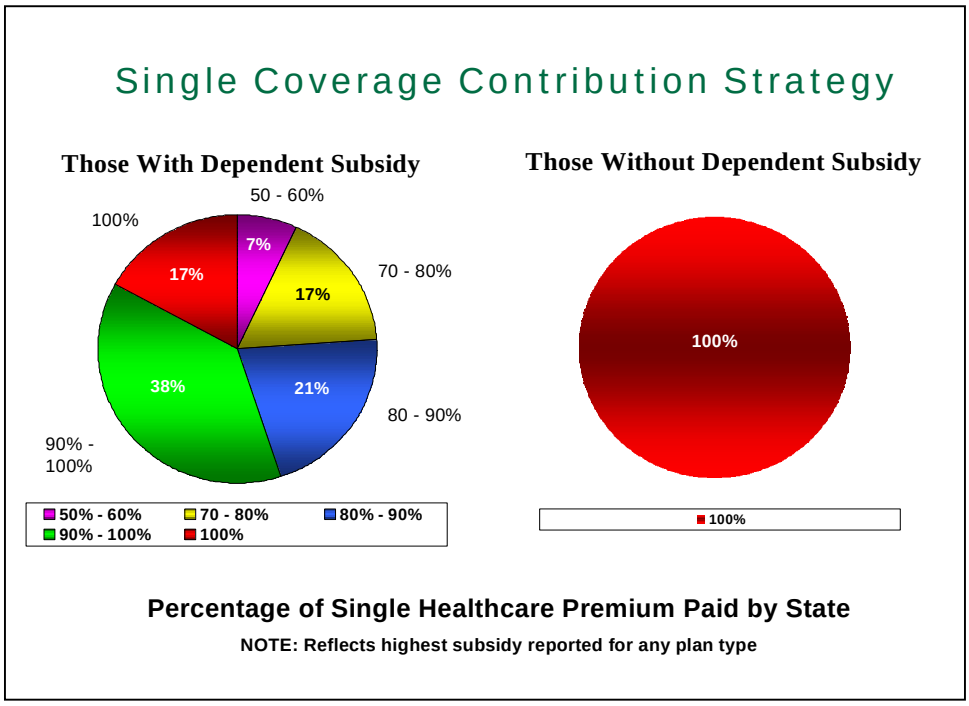
Exhibit XIV



Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

Only 17% of the states that subsidize the cost of dependent healthcare coverage for at least one plan offering pay the entire cost of single healthcare coverage for their employees. However, like the Commonwealth, all of the states that do not explicitly subsidize the cost of dependent healthcare coverage pay all of the cost of single healthcare coverage for at least one plan offering.

Exhibit XV



Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

The average employee contributions reported by other states vary somewhat by plan type. These are shown as monthly amounts in the following chart along with an average for all plan types in comparison to the Commonwealth's 2001 monthly Option A contributions. In reviewing the amounts reported by other states, bear in mind that the contributions reflect those of the most prevalent plan offered.

Exhibit XVI

	Average Employee Premium Contributions			
	Employee	**Parent+**	**Couple**	**Family**
HMO				
Other States	$33	$98	$115	$135
Commonwealth – A options	$1-$46	$118-$187	$295-$397	$354-$467
POS				
Other States	$27	$95	$130	$161
Commonwealth – A options	$14-$110	$138-$282	$324-$541	$387-$627
PPO				
Other States	$42	$129	$166	$175
Commonwealth – A options	($3) - $59	$113-$206	$286-$426	$344-$500
Overall				
Other States	$34	$104	$130	$155
Commonwealth	$22	$154	$346	$408

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

The Commonwealth offers HMO, POS and PPO options to Commonwealth Group members through five separate insurance carriers. Furthermore, the Commonwealth's contribution toward health insurance varies based on the cost of the lowest cost Option A available in each county. Therefore, the overall average employee healthcare contribution for Commonwealth Group members shown in the preceding chart reflects the average of the actual employee premium contribution amounts each member currently enrolled in an A option pays. As complete enrollment data by plan and tier is not available for the other states, each state's reported contribution for its most prevalent plan of each type was counted equally in the averages shown in Exhibit XVI.

The Commonwealth's employee contributions for individual coverage under its A options compare favorably to the average of other states' employee healthcare contributions. This is particularly true when you take into account that the Commonwealth makes at least one A option available to every employee at no cost. (The average contribution of $22 indicates that many Commonwealth employees have elected coverage under a more expensive carrier/plan type combination.)

Commonwealth Group employee premium contributions for Parent + coverage (coverage for the employee and one or more children) are around 1.5 times higher than the average for other states. Due to the lack of explicit dependent subsidies, the Commonwealth's employee premium contributions for couple (an employee and his/her spouse) and family coverage are, on average, about 2.6 times higher than the averages for other states.

The Commonwealth's weighted average contribution for health insurance in 2001 of $241 is 7% higher than the average state contribution for single coverage of $224 reported by other states for their most prevalent plans. The Commonwealth's contribution for those employees electing dependent healthcare coverage is the same as for those electing individual coverage. As the majority of other states subsidize a portion of the cost of dependent healthcare coverage, the average of other states' contributions for Parent+ coverage is $399, for Couple coverage is $416 and for Family coverage is $491.

Total Healthcare Premiums

The healthcare premium rates reported by other states for their most prevalent plan of each type vary substantially. The highest reported single rate for indemnity plans was $357 while the lowest single rate reported was $188 per month, a difference of 90%. This difference is even greater for POS, HMO and PPO options.

Based on the information collected in the survey, no correlation could be discerned between the funding arrangement, coverage of retirees or rating of retirees and the magnitude of premium rates. Both the state reporting the lowest indemnity premium rate and the state reporting the highest indemnity premium rate self fund their indemnity plan options, cover both pre-65 and Medicare eligible retirees, and pool the experience of retirees and actives. Both the state reporting the highest POS premium rate and the one reporting the lowest POS premium rate insure all of their healthcare options, cover both pre-65 and Medicare eligible retirees, and pool the experience of pre-65 retirees with actives.

The average premium rates by plan type for the A options elected by Commonwealth Group members are reflected in the table in Exhibit XVII along with the average premium rates by plan type reported by other states.

Exhibit XVII

	2001 Average Healthcare Premium Rates			
	HMO	POS	PPO	Indemnity
Single				
Other States	$248	$238	$253	$270
Kentucky	$253	$301	$258	NA
C***ouple***				
Other States*	$482	$497	$492	$552
Kentucky	$570	$673	$565	NA
Parent+				
Other States*	$412	$411	$459	$411
Kentucky	$380	$451	$382	NA
Family				
Other States*	$648	$682	$683	$709
Kentucky	$631	$752	$624	NA

* Average for states with four-tier premium rates

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

For HMO and PPO options, the Commonwealth's average single Option A premium rate is within 2% of the average reported by other states. The Commonwealth's average POS Option A premium rate is 26% higher than the average reported by other states. This difference can be explained, at least in part, by the difference in retiree enrollment:

- Retirees comprise a higher percentage of the Commonwealth's POS Option A enrollment (30%) than its HMO Option A (20%) or its PPO Option A (23%).
- In the Commonwealth Group, retirees are 25% of the total enrollment in all of the Commonwealth's POS options. However, retirees only average 4% of the POS enrollment reported by other states.

Waiver Policies and Patterns

Of thirty-six states (other than the Commonwealth) for which data was available, only 4 provide an alternative benefit to individuals who waive healthcare coverage. The alternative benefits reported include: a $25 monthly flexible spending account (FSA) contribution, a $108 monthly cash option, and a $128 flex credit. Another state indicated that it provides a cash option in lieu of healthcare coverage, but did not provide the amount.

In contrast, the Commonwealth currently provides a $234 healthcare spending account contribution to individuals who waive healthcare coverage ($234 monthly contribution for other healthcare coverage for retirees who waive healthcare coverage through the Commonwealth). Even among the small percentage of states who provide any benefit to those who waive

healthcare coverage, the Commonwealth's waiver benefit is almost double that of any other state.

Of twenty-five respondents, the percentage of eligible individuals waiving healthcare coverage varies from 0% to 27% with a median of 6%. From states' survey responses, it is obvious that a state's contribution structure affects its waiver percentage:

Exhibit XVIII

Percentage of Employees Waiving Healthcare Coverage by Employee Premium Contribution for Single Coverage	
Single Employee Contribution	**Median Wavier %**
$0	2%
$0 – $15	3%
$15 – $30	9%
$30 – $50	14%
$50+	22%

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

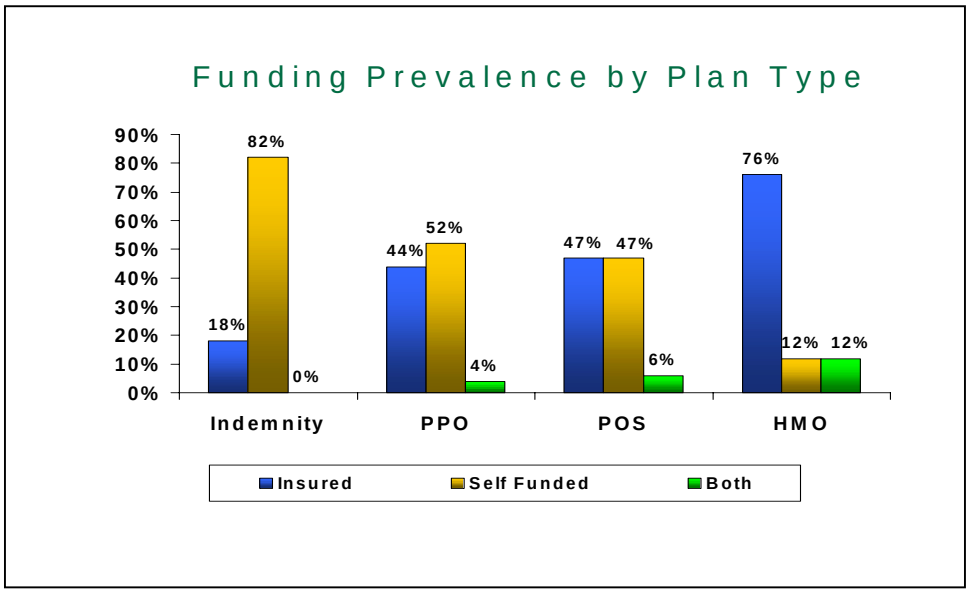
The waiver percentage for the state with a $25 monthly FSA waiver contribution was no different than other states with similar employee healthcare contributions. However, the waiver percentage for the state with a $108 monthly cash alternative benefit was 4 to 5 percentage points higher than other states with similar employee contributions for single coverage.

Although the Commonwealth pays 100% of the cost of single coverage for the lowest cost Option A available in every county, its waiver percentage as of February 2002 was 17%. The significant difference between the Commonwealth's waiver percentage and that of other states who pay the full cost of single coverage for at least one healthcare option strongly supports the premise that eliminating the state's FSA waiver contribution in its entirety would *not* significantly reduce its healthcare costs. The data from other states indicates that the vast majority of Commonwealth Group members currently waiving healthcare coverage would enroll in a state sponsored healthcare option if the FSA waiver contribution were eliminated.

Funding Arrangements

The method of funding – insured vs. self-funded – reported by other states varies based on the type of plan being offered. As illustrated in the following chart, the majority of indemnity plans offered by other states are self-funded. Like the Commonwealth, the majority of HMOs offered by other states are insured. Funding arrangements for PPO and POS options in other states are split about equally between insured and self-funded arrangements. (Those states that insure one or more options of a particular type and self-fund other options of that type are shown as *Both*.)

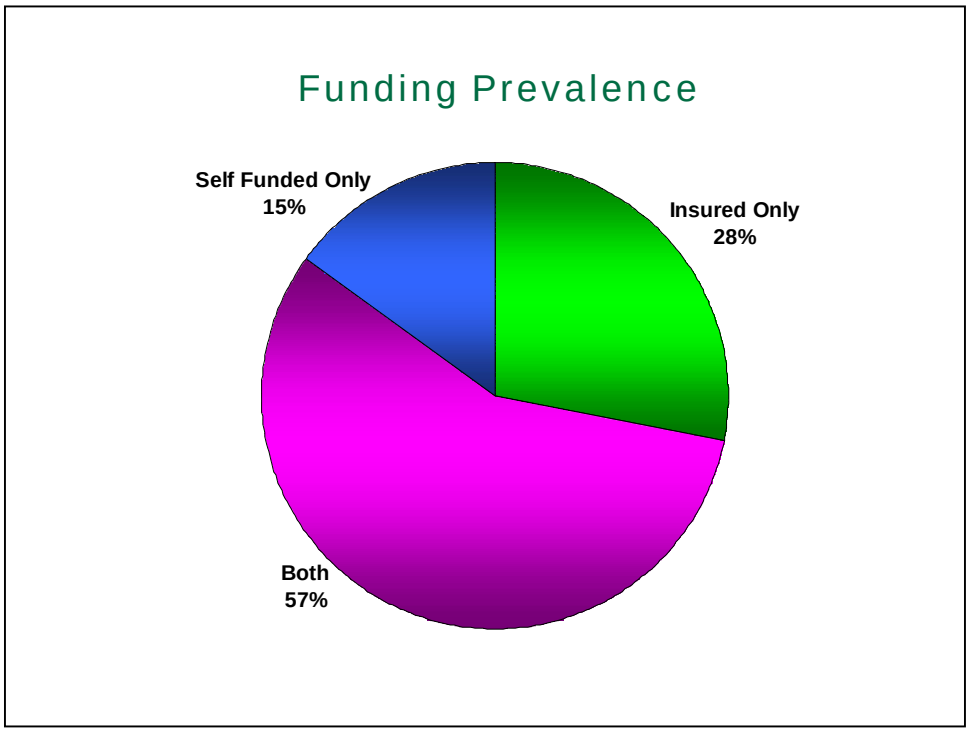
Exhibit XIX



Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

Many states, like the Commonwealth, offer more than one plan type. A separate analysis of the funding arrangements employed by states for all of their plans was conducted. This analysis, presented in the following chart, revealed that a slight majority of other states have a split funding arrangement - some of their plans are insured and some are self-funded.

Exhibit XX



Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

Retiree Coverage

As noted previously, like the Commonwealth, the majority of states (92%) cover pre-65 retirees under the same healthcare program as active employees. However, about 30% of other states rate these retirees separately from active employees – either through a separate program or separate rating under a combined program.

Forty-six percent of other states indicated that they offer a PPO option to their out-of-state retirees. Thirty-eight percent indicated that they offer an indemnity plan option to out-of-state retirees. Eight percent of these offer both an indemnity and PPO option to out-of-state retirees. Another 5% provide PPO out-of-network benefits, similar to the Commonwealth. The others had varying approaches to meeting the healthcare needs of out-of-state retirees.

Retiree premium contribution strategies vary among the states.

Exhibit XXI

Retiree Healthcare Premium Contributions in Other States	
Same as active employees	21%
Based on years of service	28%
Retirees pay the full cost	21%
Other	30%

Source: 2001 Survey conducted by OPEHI and William M. Mercer, Incorporated

Twenty-one percent of other states require the same contribution of pre-65 retirees as they do of active employees. However, 28% base pre-65 retirees' contributions on years of service. Another 21% require retirees to pay the full cost of coverage, although one of these states makes an additional contribution of $4 per month per year of service to help the retiree fund the cost of this coverage. Another allows employees to cash out unused sick leave at retirement which can be used as a source of funds to pay for this coverage. The other 30% employ varying strategies, including the following:

- retirees pay $138 for single coverage and $302 monthly for family coverage;
- the state pays 75% of the cost of PPO coverage;
- the state pays 65% of the lowest cost option;
- retirees pay 11% of the active rates;
- retirees pay 1 ½ times the amount active employees pay for single coverage; and
- at age 60 with 15 years service or 25 years service, the full cost is paid by the state, for those with 10 to 25 years service, the retiree pays the direct pay rate less $5.

The Commonwealth requires the same health insurance premium contribution of pre-65 retirees as applies to active employees, for individuals with 20 or more years of service. For retirees with less than 20 years of service but at least four years, the Commonwealth contributes a percentage of the amount it contributes for active employees as outlined in the following table.

Exhibit XXII

Commonwealth's Retiree Healthcare Premium Contribution		
Years of Service at Retirement		Percentage of Active Employee Contribution Paid by the Commonwealth
At Least	Less Than	
4	10	25%
10	15	50%
15	20	75%
20	–	100%

Findings

- The Commonwealth's Public Employee Health Insurance Program differs from that of other states in the groups that are covered. The majority of other states cover university employees while only regional university ***retirees*** are members of the Commonwealth Group. Although part of the Commonwealth Group, less than half (42%) of other states cover teachers and health board employees. Most importantly, ***retirees of local governments*** are members of the Commonwealth Group. Only 24% of other states indicated that they cover local government actives or retirees.
- The Commonwealth offers a choice of more healthcare options to Commonwealth Group members than most other states.
- Thirty percent of other states offer an indemnity healthcare option to all their employees. An additional 6% offer an indemnity option to out-of-state employees/retirees. The Commonwealth does not offer an indemnity option.
- Although the Commonwealth offers PPO options with the same benefit provisions in 115 of 120 Commonwealth counties, and an EPO C option with consistent benefit provisions statewide, employee contributions for these options vary based on the insurance carrier(s) willing to offer coverage in each county. Unlike the majority of other states (88%), the Commonwealth does not offer a consistent healthcare option statewide.
- Although some of the co-payments in the Commonwealth's options are higher than the median reported by other states, actuarially, the Commonwealth's HMO A option is around 99% of the value of the median HMO option offered by other states. The actuarial value of the Commonwealth's POS A option is within ½ of 1% of the value of the median POS option offered by other states, and the Commonwealth's PPO A option is within 6% of the value of the median PPO option offered by other states.
- Almost 80% of other states offer a mail order prescription drug feature within their employee healthcare program. This provision is not currently included in the Commonwealth's Public Employee Health Insurance Program.

  When structured properly, both the health plan and its members save valuable prescription drug dollars when a mail order pharmacy feature is included. Members typically pay lower co-payments and receive the added convenience of ordering and receiving prescription drugs at their homes. For example, an employee or retiree who currently purchases 48 maintenance brand name prescriptions annually would pay $720 in prescription drug co-payments under the Commonwealth's Public Employee Health Insurance Program A options. If a mail order

option were incorporated, with 90 days of medication available for 2 retail co-payments, the employee/retiree would pay only $480 in co-payments for these same prescriptions, saving $240 annually, or 33% of the cost of his/her maintenance prescriptions.

A health plan's mail order savings varies based on its underlying reimbursement arrangements for both retail and mail prescriptions, drug mix, and utilization. In general, it is estimated that a plan like the Commonwealth's could save up to 1% of prescription drug costs for every 10% of prescriptions that are filled via mail, if a mail order pharmacy provision were added where the mail order co-payment for a 90-day supply of a maintenance drug is 2 times the retail co-payment for a 30-day supply of the same drug.

- For HMO and PPO options, the Commonwealth's average total single Option A premium rate is within 2% of the average reported by other states. The Commonwealth's average POS Option A premium rate is 26% higher than the average reported by other states. This difference can be explained, at least in part, by a substantial difference in retiree POS enrollment between the Commonwealth Group and other states.
- The most striking difference between the Commonwealth's healthcare program and that of other states is the state's contribution strategy.
  - The majority of other states (88%) subsidize the cost of dependent healthcare coverage. Of these, 83% require employees to pay a portion of individual healthcare coverage premiums. The Commonwealth does not directly subsidize the cost of dependent healthcare coverage and pays the full cost of single coverage for the lowest cost Option A in each county.
  - Few states (11%) provide an alternative benefit to individuals who waive healthcare coverage. The Commonwealth's waiver benefit is almost double that of any other state. However, data from the other states indicates that the vast majority of individuals currently waiving healthcare coverage through the Commonwealth would enroll in a state sponsored healthcare option if the Commonwealth's FSA waiver contribution were eliminated entirely.
- While the majority of states (72%) sponsor at least one self-funded plan, only 15% self-fund their entire healthcare program. The Commonwealth's insured funding arrangement is consistent with other states in view of the plan types it offers to employees and the heavier concentration of Commonwealth Group members enrolled in HMOs.
- Like other states, the Commonwealth extends healthcare coverage to early retirees. However, it appears to be unique in covering some retiree groups for which the corresponding active group does not participate in the Commonwealth's program. In general, the Commonwealth's pre-65 retiree healthcare coverage is more generous than that of most states.

Dependent Coverage

Implicit Subsidies

Currently, the Commonwealth of Kentucky does not explicitly subsidize the cost of healthcare coverage for employees' and retirees' dependents. However, there are two types of implicit subsidies incorporated in the Commonwealth's health insurance program:

- through the premium rate relationship that exists between the single premium rate and dependent coverage premium rates, and
- through the fixed dollar contribution the Commonwealth makes available to employees and retirees.

Each of these is explained below.

Premium Rate Relationship Among Coverage Tiers

For all healthcare options the Commonwealth makes available to employees and retirees, the same specified relationships between the single premium rate and dependent coverage premium rates apply as outlined in the following table.

Exhibit XXIII

Commonwealth's Premium Rate and 2000 Claims Relationship by Coverage Level		
Coverage Level	**Premium Rate Relationship**	**2000 Claims Relationship**
Employee/Retiree Only	1	1
Couple	2.25 x Employee/Retiree	2.06 x Employee/Retiree
Parent+	1.5 x Employee/Retiree	1.61 x Employee/Retiree
Family	2.5 x Employee/Retiree	2.72 x Employee/Retiree

Source: William M. Mercer, Incorporated based on data provided by the Commonwealth's insurers

However, when the average claims for covered spouses and children for plan year 2000 are compared to the average claims for covered employees and retirees, the resulting claims relationships differ from the corresponding premium rate relationships:

- The average employee/retiree claim figure plus the average spouse claim figure is 2.06 times the employee/retiree average claim amount.
- When the average employee/retiree claim amount is combined with the average claim cost per child and adjusted for the average number of children covered by individuals with parent + coverage, the average claims cost for parent + coverage is 1.61 times the average claims cost for employees/retirees.
- For family coverage, when the average employee/retiree claim amount is combined with the average claim cost per child (adjusted for the average number of children covered by individuals with family coverage) and the average spouse claim figure, the result is 2.72 times the employee/retiree claim cost.

The premium rate relationships employed by the Commonwealth resulted in an implicit

Commonwealth subsidy for dependent coverage of roughly $5.6 million in plan year 2000.

It is important to note that if spouse claims for individuals enrolled in couple coverage were separately analyzed from spouse claims for individuals with family coverage, it is likely that the average claims cost for couples in relation to the average claims cost for employees/retirees would be higher than reflected above. The relationship of the claims cost for families to that of employees/retirees alone would be lower than reflected above. This is due to the fact that spouses of those individuals electing couple coverage are, on average, ten years older than the spouses of individuals electing family coverage.[13]

Fixed Dollar Contribution

In plan year 2000, the Commonwealth provided a contribution toward employee/retiree healthcare coverage equal to the greater of $214 per month or the single coverage premium for the lowest cost option A plan available in the county in which the individual resided or worked. Individuals who elected coverage under an option where the single coverage cost was less than the Commonwealth's contribution could apply those dollars in excess of the single coverage premium toward the cost of covering their dependents. For example, those individuals electing PPO Option B through Bluegrass Family Health could apply $17.34 of the Commonwealth's monthly contribution toward the additional cost of dependent coverage. In fact, 12,472 Commonwealth members elected dependent coverage under an option where the single coverage cost was less than the Commonwealth's contribution. This resulted in about $2 million of the Commonwealth's contribution being applied to dependent coverage in 2000.

Explicit Subsidies

Even with the implicit subsidies that the Commonwealth provides towards dependent coverage, employees' and retirees' contributions for dependent coverage, particularly full family coverage, are significant. For this reason, employee groups have lobbied for paid dependent coverage through explicit Commonwealth subsidies in the past. However, as indicated previously, the Employee Advisory Committee has recommended that the Commonwealth not modify its policy of paying the full cost of single coverage under the lowest cost option A in order to fund a portion of the cost of dependent coverage.

The *Workplace Economics, Inc. 2000 State Employee Benefits Survey* indicates that 82% of states, other than Kentucky, subsidize a portion of the cost of dependent coverage. Of these, only 30% pay the full cost of single coverage. For the other 70%, on average, state employees paid $31 per month for single coverage in 2000. These results are similar to the results of the Commonwealth's own survey of states' 2001 healthcare programs as provided in the preceding section. However, responses to the Commonwealth's survey indicate that only 17% of the states that subsidize dependent healthcare coverage premiums pay the full cost of single healthcare coverage.

[13] *Source: OPEHI eligibility data as of February 2001*

Based on its 2001 group demographics and premium rates, the estimated cost if the Commonwealth were to offer explicit dependent subsidies, without revising other aspects of its contribution strategy or benefit offerings, is illustrated below:

Exhibit XXIV

Dependent Subsidy Cost Estimates	
Dependent Subsidy	**Estimated 2001 Commonwealth Cost *(in millions)***
25%	$37.5
50%	$119.8
70%	$202.4
80%	$274.2
90%	$365.5
100%	$445.9

Source: William M. Mercer, Incorporated

Healthcare enrollment is affected by the premium contribution amount employees have to pay for coverage. Therefore, enrollment had to be estimated for each dependent subsidy percentage in the preceding table. Using the Commonwealth's February 2001 enrollment as the baseline, the assumed enrollment percentages for each subsidy level are reflected in the following table.

Exhibit XXV

	Estimated Commonwealth Enrollment Under Various Dependent Subsidy Levels						
	No Subsidy*	25% Subsidy	50% Subsidy	70% Subsidy	80% Subsidy	90% Subsidy	100% Subsidy
Waivers	17%	16%	15%	14%	10%	5%	2%
Cross References	3%	3%	3%	3%	3%	3%	3%
Single	53%	50%	39%	33%	29%	25%	21%
Couple	6%	7%	8%	9%	12%	15%	17%
Parent+	11%	11%	12%	12%	12%	12%	14%
Family	10%	13%	23%	29%	34%	40%	43%
Total Contracts	80%	81%	82%	83%	87%	92%	95%

*Commonwealth Group enrollment as of February 2001

Source: William M. Mercer, Incorporated

These enrollment figures reflect Mercer's best estimates based on other employers' enrollment patterns with various contribution structures. However, as employees' health insurance choices are based on a variety of factors, including the healthcare coverage available to employees' spouses, actual enrollment, and therefore the additional cost to the Commonwealth, may vary as much as 20% from the figures reflected above. Furthermore, the estimated cost figures are based on the Commonwealth's 2001 healthcare premium rates. As healthcare costs increase in the future, the estimated cost to provide dependent subsidies will increase correspondingly.

Options Considered

Prior to developing its recommendations, the Board researched several options that might be pursued to provide funding for dependent health insurance premium subsidies, in case additional funds could not be appropriated for this purpose. In addition to:

- Recouping an estimated $18 million in forfeitures from the healthcare flexible spending accounts of individuals waiving health insurance through the Commonwealth Group, and
- Placing an assessment of around $10 million on entities whose retirees participate in the Commonwealth Group but whose active employees do not

the Board also considered:

- Reducing the Commonwealth's contribution to the healthcare flexible spending accounts of those individuals who waive health insurance through the Commonwealth Group.

  Exhibit XXVI shows the estimated savings in 2001 if the Commonwealth's FSA contribution had been reduced ***and*** FSA forfeitures were recouped from all Commonwealth Group entities. (Please note that these figures include not only the estimated funds from reducing the Commonwealth's FSA contribution, but also the projected dollars from recouping FSA forfeitures. Therefore, the figures in the following chart *should not be added* to the $18 million in estimated forfeitures under the current contribution structure.)

  In reviewing the following chart, bear in mind that if the Commonwealth reduced its healthcare FSA contribution for individuals waiving health insurance coverage, some of the individuals waiving coverage today would enroll in a Commonwealth-sponsored health insurance plan. Additionally, the amount of FSA forfeitures would decline if the Commonwealth's FSA contribution was decreased. As virtually all current healthcare waivers would enroll in a Commonwealth health insurance option, if the healthcare FSA waiver contribution were eliminated entirely, the annual savings from eliminating the healthcare FSA waiver contribution would only be expected to be around $3 million annually. The estimated savings shown in the following chart take into account both the expected number of health insurance waivers who would enroll in a Commonwealth-sponsored health insurance plan and the reduced amount of FSA forfeitures that would result, if the Commonwealth reduced its healthcare FSA waiver contribution amount.

Exhibit XXVI

Annual Savings if Commonwealth Reduced FSA Waiver Contribution and Began Recouping FSA Forfeitures		
% of Current Contribution	**Annual FSA Contribution Amount**	**Estimated Annual Savings**
0%	$0	$3 million
25%	$700	$29 - $36 million
50%	$1,400	$33 – $41 million
75%	$2,100	$28 - $30 million

Source: William M. Mercer, Incorporated

- Revising the Commonwealth's funding of single health insurance coverage from 100% of the premium for single coverage under the lowest cost Option A available in every county to 90%. In 2001, Commonwealth Group members waiving health insurance coverage would have received an FSA contribution of $211 per month rather than $234. In total, about $35 million in savings would have been expected for 2001 from these revisions, approximately $27 million from the reduction in funding for those with single health insurance and around $8 million from the reduction in flexible spending account contributions for those waiving health insurance.

Assuming the Commonwealth implemented all of the following changes, it is estimated that there would be about $75 million in annual funding available, enough to provide a 35% dependent premium subsidy in 2001.

- Reduce the Commonwealth's FSA contribution to those waiving health insurance by 50% and recoup all unused FSA funds (about $38 million),
- Contribute only 90% of the cost of single coverage for the lowest cost Option A in each county (around $27 million), and
- Require groups whose retirees participate in the Commonwealth Group, but whose active employees do not, to pay the additional cost for their retirees (approximately $10 million).

Exhibit XXVII illustrates the 2001 employee contributions for the Option A plans, if all of the above changes had been made, in comparison to the 2001 employee premium contributions under the current structure.

Exhibit XXVII

	Current 2001 Employee Contributions vs. 2001 Contributions if Commonwealth Paid 90% of Single and 35% of Dependent Rate for Lowest Cost Option A			
	Employee	**Parent+**	**Couple**	**Family**
HMO				
Proposed Option A	$27 - $72	$104 – $172	$220 - $322	$258 - $372
Current Option A	$1 - $46	$118 - $187	$295 - $397	$354 - $467
POS				
Proposed Option A	$40 - $136	$124 - $268	$249 - $465	$291 - $531
Current Option A	$14 - $110	$138 - $282	$324 - $541	$387 - $627
PPO				
Proposed Option A	$23 - $85	$98 - $192	$211 - $351	$249 - $404
Current Option A	($3) - $59	$113 - $206	$286 - $426	$344 - $500

Source: William M. Mercer, Incorporated

Findings

- While the Commonwealth does not directly pay any portion of healthcare premiums for dependents, by virtue of the relationship established between its single and dependent coverage premium rates, it implicitly subsidized the cost of dependent coverage in 2000 by roughly $5.6 million. Additionally, Commonwealth Group members applied about $2 million of the Commonwealth's healthcare contribution in 2000 to dependents' coverage from its fixed dollar contribution.
- Although the Commonwealth implicitly subsidizes the cost of dependent healthcare coverage, Commonwealth Group members' premium contributions for dependent healthcare are significant. In comparison to other states, which typically pay 50% or more of the cost of dependent healthcare coverage, Commonwealth Group members' dependent healthcare premium contributions are:
  - 50% higher for Parent+ coverage than the average of other states, and
  - 2.6 times the average employee contribution for Couple and Family coverages.
- The magnitude of dependent healthcare coverage premium increases in 2000 appears to have led to a decline in the number, and percentage, of Commonwealth Group members electing coverage for their spouse (Couple and Family coverage). Overall, about 1,750 fewer employee/retirees elected dependent coverage in 2000 than 1999.
- If dependent subsidies were implemented by the Commonwealth, without any offsetting changes in the Commonwealth's Public Employee Health Insurance Program, the estimated additional annual cost ranges from roughly $38 million if the Commonwealth paid 25% of dependent healthcare premiums to $446 million if the Commonwealth paid 100% of dependent premiums. As premium contributions affect employees' healthcare elections, enrollment changes had to be estimated in order to project costs under various dependent subsidy alternatives. Therefore, actual costs may vary from estimated by as much as 20%. Furthermore, these cost estimates are based on February 2001 Commonwealth Group enrollment and premiums. The additional Commonwealth cost to subsidize dependent

healthcare premiums will increase annually at the same rate as the employee healthcare premiums paid by the Commonwealth.

- The Employee Advisory Committee does not want dependent subsidies, if the Commonwealth chose to fund any portion of the cost to do so by modifying its policy of paying the full cost of single coverage under the lowest cost Option A available in each county. However, the Board researched options to fund a dependent premium subsidy that included:
  - Reducing the Commonwealth's contribution for single health insurance from 100% to 90% of the cost of the lowest cost Option A available in each county. This option would have generated funding of about $27 million in 2001.
  - Reducing the Commonwealth's contribution to the healthcare flexible spending accounts of individuals who waive health insurance through the Commonwealth Group, in conjunction with recouping FSA forfeitures from all entities participating in the Commonwealth Group. These two steps would have generated around $38 million in aggregate in 2001.
  - Requiring groups whose retirees participate in the Commonwealth Group, but whose active employees do not, to pay the additional cost for their retirees, approximately $10 million.

  In total, these options would have generated about $75 million in 2001, enough to fund up to 35% of dependent health insurance premiums.

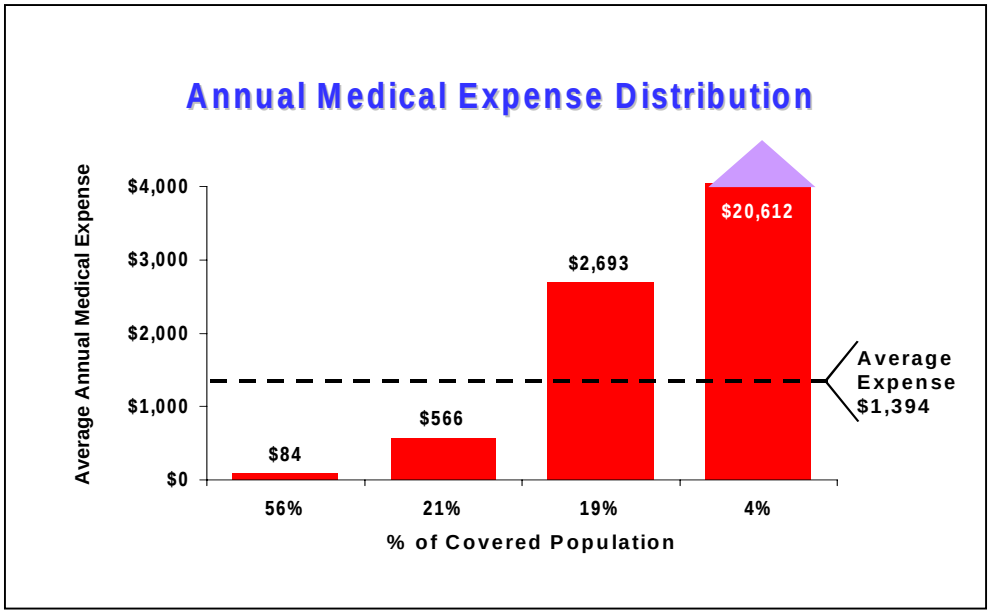
Adverse Selection

Explanation

Whenever individual health plan participants are offered a choice of health plan options, adverse selection will result. Adverse selection is the additional cost that results when an individual selects the plan that minimizes his/her out of pocket expenditures, and thereby maximizes the plan's cost.

If every individual's claims were average or close thereto, there would be no or little potential for adverse selection. However, in a typical population, a substantial percentage of the covered population will have very low claims cost and a very small percentage will incur significant claims. This is illustrated by the following chart, drawn from a database of over 2 million covered lives.

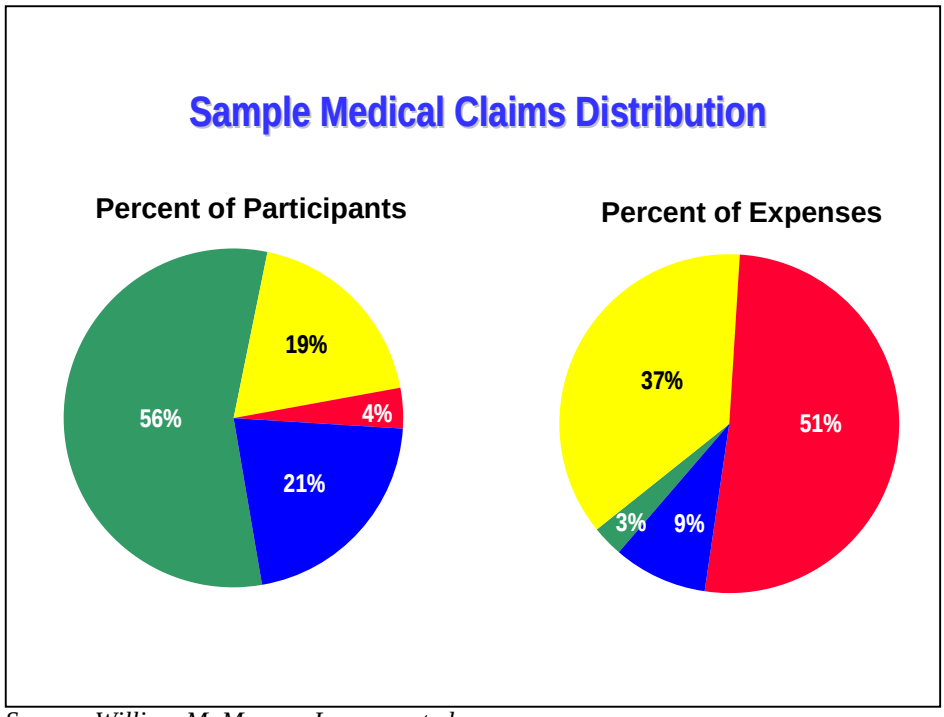
Exhibit XXVI



Source: William M. Mercer, Incorporated from CHAMP 1998 book of business data

The average medical expense for the group reflected above was $1,394 annually per covered individual. However, the annual expense for 56% of the population only averaged $84, while the annual expense for 4% of the population exceeded $20,600. Illustrated in another manner below, 56% of the population generated only 3% of the plan's expense (shown in green), while 4% of the population generated 51% of the plan's expense (shown in red).

Exhibit XXVII



Source: William M. Mercer, Incorporated

There are several factors that can influence the cost differential resulting from selection. These include:

- the differential between the provisions in the various plan options offered;
- the composition of the provider network available for each plan option;
- the level of contributions that employees and retirees must pay to enroll in each healthcare option and level of coverage (single, couple, parent+, family);
- whether the group is consolidated under a single risk arrangement or it is divided into separate risk pools, for example with different insurance carriers;
- the ability for groups that comprise the aggregate group to enter or exit the group arrangement or for individuals to elect to join the group/continue coverage through the group; and
- rating policies that are applied in establishing premium rates between various plan options and levels of coverage.

Individual Selection

In the past, bills have been introduced that would have allowed individuals who are not employees or retirees of the Commonwealth or groups that participate in a state-sponsored retirement plan to join the Commonwealth Group. These individuals would be expected to have much higher healthcare claims than other Commonwealth Group members, due to the impact of individual selection. To illustrate the impact that individual selection can have on healthcare costs, the average healthcare claims of COBRA individuals who elected coverage through the Commonwealth Group in 2000 were extracted from the data reported by the Commonwealth Group's insurance carriers. In comparison to the average 2000 healthcare claims for other

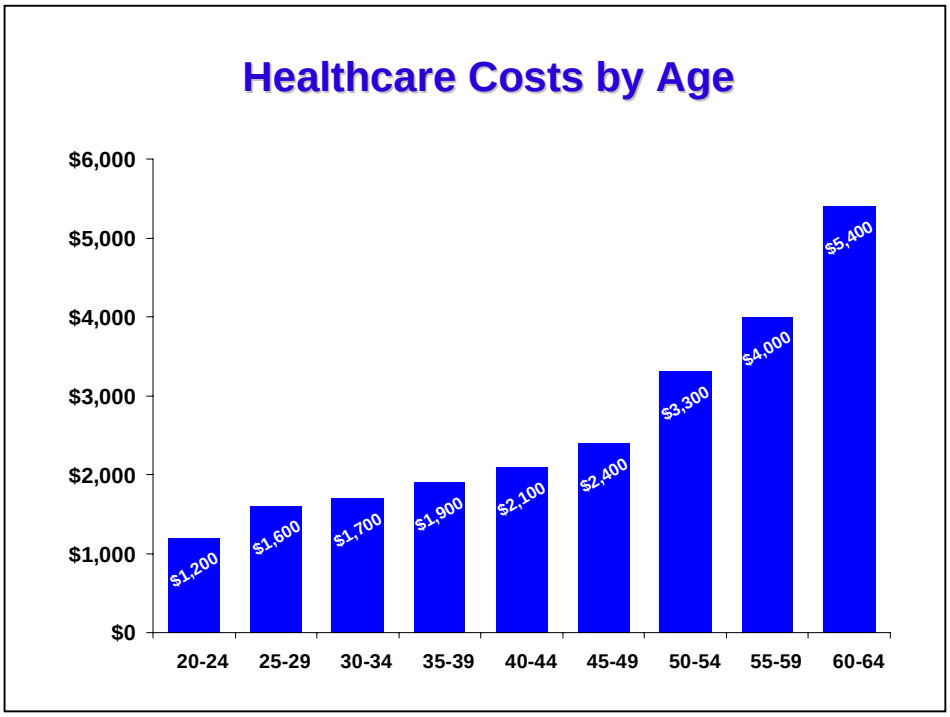
Commonwealth Group members, the average claim figure for COBRA members was over 150% higher. (The COBRA group's average claims cost per covered individual was 2½ times that of other Commonwealth Group members.)

Retirees

Individuals who participate in a state sponsored retirement program are eligible to participate in the Commonwealth's health insurance programs. These retirees include not only former employees of state agencies and school boards but also former employees of cities, counties, and municipalities that participate in the CERS program and former employees of regional universities. Health insurance coverage for the pre-65 retirees of the Commonwealth's KTRS, KERS, SPRS and CERS programs is provided through the same program that covers active state employees. However, active employees of the Commonwealth's regional universities do not participate in the Commonwealth's health insurance program, neither do active employees of most of the cities, counties and municipalities that participate in the CERS program. Rather, these entities maintain separate health insurance programs for their active employees. (A list of the entities whose retirees participate in the Commonwealth Group but whose active employees do not is provided in Appendix B.[14] This list also provides the total number of active employees and retirees for each of these entities that participate in a state-sponsored retirement plan.)

Health care needs and therefore costs increase as individuals age, particularly once an individual reaches his/her mid-forties and beyond. To illustrate the impact age has on healthcare costs, healthcare expenses for about three-quarters of a million claimants are shown by age below.

Exhibit XXVIII



Source: William M. Mercer, Incorporated based on 1998 CHAMP book of business extract

In this sample, healthcare costs for those between ages 40 and 44 are 10.5% higher than for those between ages 35 and 39. However, costs for those between the ages of 50 and 54 are 37.5% higher than for those age 45 to 49 and 57% higher than for those age 40 to 44.

[14] *Source: Kentucky Retirement Systems*

Premium costs for the Commonwealth Group are negatively impacted by the fact that the retirees of CERS and regional universities participate in the Commonwealth's healthcare program while the active employees of these employers do not. For calendar year 2000, the average annual healthcare claims cost per covered life for CERS and regional university pre-65 retirees and their covered dependents for whom the corresponding active employee group does not participate in the Commonwealth's Public Employee Health Insurance Program, was $3,095. For all other individuals of the Commonwealth Group, including KERS and KTRS retirees and their dependents, the average annual healthcare claims cost for calendar year 2000 was $1,978. Based on these figures, the 5,790 CERS and regional university retirees and their 3,072 covered dependents that participated in the Commonwealth Group in 2000, for whom the corresponding active employee group did not, added roughly $9.9 million in excess cost that was absorbed by the Commonwealth and other Commonwealth Group members.[15]

Mitigation Actions To-Date

The Commonwealth of Kentucky has addressed some of these factors in the Commonwealth's Public Employee Health Insurance Program. Actions to date have included:

- prescribing the relationship between premium rates for single, parent+, couple, and family coverage;
- establishing an allowable range for the relationship between Option A and Option B premium rates for the same plan type (HMO, POS or PPO); and
- requiring insurance carriers who offer coverage to Commonwealth Group members to charge the same premium for the same plan type (HMO, POS, PPO, EPO) and option (A, B or C) in all counties where they bid throughout the Commonwealth.

Premium Rate Relationship Among Coverage Tiers

Under an arrangement with multiple insurance carriers, like the Commonwealth currently has in place, each carrier may attempt to attract a certain type of risk by the way in which it structures its premium rates. This can be illustrated by reviewing the relationship of Parent+, Couple and Family premium rates to Single coverage premium rates under the Health Purchasing Alliance in 1998. As illustrated in the following chart, these relationships varied substantially among the insurance carriers and options available to members of the Health Purchasing Alliance, including individuals that are now participants in the Commonwealth Group.

[15] *MedStat, based on data submitted by the Commonwealth's insurance carriers.*

Exhibit XXIX

	Premium Rate Relationships	
	1998 Purchasing Alliance	1999 and Beyond
Single	1.0	1.0
Parent +	1.34 – 1.75 x Single Rate	1.5 x Single Rate
Couple	1.97 – 2.38 x Single Rate	2.25 x Single Rate
Family	2.14 – 2.80 x Single Rate	2.5 x Single Rate

Source: OPEHI and William M. Mercer, Incorporated

In 1998, the Parent+ premium rate ranged from 1.34 to 1.75 times the corresponding single premium rate. The Couple premium rate ranged from 1.97 to 2.38 times the corresponding single premium rate, and the Family rate from 2.14 to 2.8 times the single premium rate. In fact, there were situations where the family premium rate was less than the couple rate. This was likely because of a desire of the insurance carriers offering coverage under the Purchasing Alliance to attract the best risks, as those individuals electing Couple coverage were likely older empty-nesters, while those electing Family coverage were likely younger. (As previously noted in the Dependent Coverage section, in 2000, spouses of those Commonwealth Group members electing Couple coverage were, on average, 10 years older than spouses of the Commonwealth Group members electing Family coverage.)

When the Personnel Cabinet took over responsibility for the Commonwealth's Public Employee Health Insurance Program in 1999, it "risk adjusted" the premium rates paid to insurance carriers by establishing required relationships between dependent coverage premium rates and the single coverage cost. As illustrated above, these relationships were generally established at the mid-point of the range of relationships that were in effect in 1998 to mitigate, to the extent possible, fluctuations in premium rates due to this stipulation while still leveling the playing field amongst the parties insuring Commonwealth Group members.

Premium Rate Relationship Between A and B Options

The Commonwealth offers employees and retirees two HMO, two POS and two PPO options. The A options provide higher benefit levels, and therefore have higher premium costs. The B options have lower benefit levels, and therefore, lower premium costs. When a choice of high and low options is offered to individual health plan participants, it is common for those individuals with lower healthcare costs to select the lower cost healthcare option (i.e. option B). This typically results in a lower loss ratio, a greater difference between the premium charged and the claims paid, and therefore more money for operating expenses and/or profit for the insurance carriers insuring a larger segment of option B plan participants. In analyzing its premiums, the Commonwealth noted that the differential between the option A and option B premium rates varied substantially by carrier and fluctuated from year to year as illustrated in the following table.

Exhibit XXX

	Option A Rate/Option B Premium Rate Relationship		
	Low	High	Unweighted Average
1999	1.05	1.20	1.13
2000	1.05	1.18	1.09
2001	1.05	1.37	1.14
2002	1.05	1.11	1.10

Source: OPEHI and William M. Mercer, Incorporated

Therefore, effective with the 2002 plan year, the Office of Public Employee Health Insurance stipulated a permitted range for the differential between the Option A and Option B premium rates for a given plan type (HMO, POS or PPO). This stipulation provides that the Option B rate has to be at least 5% but no more than 10% lower than the Option A rate. Stated another way, the Option A rate must be at least 5.3% higher but no more than 11.1% greater than the Option B rate. This stipulation is another of the risk adjustments that the Commonwealth has implemented since the Personnel Cabinet took over responsibility for the Commonwealth's Public Employee Health Insurance Program.

Geographic Cost Differential Blending

The amount providers charge for various healthcare services varies between different geographic areas within the Commonwealth.[16] To blend these low and high cost areas, thereby equalizing, to the degree possible, employee contributions for dependent coverage, the Commonwealth requires insurance carriers to charge the same premium for the same plan type and option in all counties where they offer coverage to Commonwealth Group members. This is consistent with the provision in KRS 18A.225(2)(c), enacted by the 2000 General Assembly under Senate Bill 288, that requires insurance carriers to rate all members of the Commonwealth Group, other than retirees whose former employees insure their active employees outside the Commonwealth Group, as a single entity.

Bills have been introduced in the past that would allow the Commonwealth's insurance carriers to charge different rates in different areas of the state. If this provision were enacted, especially in conjunction with a provision that would preclude the Commonwealth from restricting the number of insurance carriers offered in a given geographic area, the Commonwealth's insurance carriers would have no incentive to blend the costs of high and low cost areas. Although the Commonwealth funds the lowest cost single Option A in a given county, Commonwealth Group members pay the entire premium attributable to their dependents' coverage. Therefore, if the current geographic rate blending employed by the Commonwealth and supported by KRS 18A.225(2)(c) were eliminated, Commonwealth Group members' premium contributions for dependent coverage would increase in areas with higher healthcare costs.

[16] *Source: Confidential and proprietary data submitted by bidders responding to the Commonwealth's health insurance RFP*

Other Adverse Selection Mitigation Methods

In addition to the aforementioned adverse selection mitigation methods, the Commonwealth could choose to mitigate the cost of adverse selection in its healthcare program by:

- restricting the ability of groups and/or individuals to enter/exit the Commonwealth Group;
- reducing its healthcare options to one;
- consolidating its risk pool through self-funding or under an insured arrangement through one insurance carrier; and/or
- risk adjusting rates based on age, gender and/or health status.

Given its complexity and the potential controversy that could result from the adoption of a risk adjustment mechanism based on the age, gender and/or health status of enrollees, a separate section follows that discusses this approach in more detail.

Comprehensive Risk Adjustment

Risk adjustments based on the age, gender or health status of the individuals who enroll in a particular healthcare option are controversial, since they result in premium adjustments after individuals have selected the health plan in which they wish to enroll. Additionally, some insurers could legitimately argue that the segment of the Commonwealth Group enrolled in the plans they insure has a better health status profile due to their efforts with respect to preventive care or the management of care for individuals with chronic health conditions.

From an analysis of the age and gender demographic characteristics of the segment of the Commonwealth Group enrolled with each insurer and an actuarial table of health plan cost relationships based on age and gender, it was determined that the risk profile of the group with the age/gender profile that should generate the lowest healthcare cost was 2.8% lower than the Commonwealth Group overall. The risk profile of the groups insured by the insurance carriers covering segments of the Commonwealth Group with the age/gender profile that would indicate higher healthcare costs was 2.4% above the average risk profile of the group overall. This results in an expected cost differential of 5.3% between the insurer covering the group with the lowest expected healthcare cost, based on age and gender, and the insurers covering the groups with age and gender characteristics that would be expected to generate the highest healthcare cost.[17]

Bear in mind that age and gender are only two factors that could be used in risk adjusting premiums to be paid to the Commonwealth's insurance carriers. Other factors could include:

- geographic differences in provider charges in various areas of the Commonwealth;
- the composition of the health plan's provider network and its negotiated reimbursement arrangements with those providers; and
- the health status of individual Commonwealth Group members enrolled with each insurer.

To this point, the Commonwealth has not employed the complex and controversial risk adjustment mechanisms that would modify the premiums payable to each of its insurance carriers based on demographic and/or health status characteristics of the Commonwealth Group members electing coverage through each carrier.

[17] *William M. Mercer, Incorporated based on data submitted by Commonwealth Group insurers*

Findings

- Adverse selection results whenever individual health plan participants are offered a choice of health plan options.
- To-date, the Commonwealth has taken the following actions to mitigate adverse selection in the Commonwealth's Public Employee Health Insurance Program:
  - prescribing the relationship between premium rates for single, parent+, couple, and family coverage;
  - establishing an allowable range for the relationship between Option A and Option B premium rates for the same plan type (HMO, POS or PPO); and
  - requiring insurance carriers who offer coverage to Commonwealth Group members to charge the same premium for the same plan type (HMO, POS, PPO, EPO) and option (A, B or C) in all counties where they bid throughout the Commonwealth.
- In 2000, the average claims cost for Commonwealth Group retirees and their covered dependents of cities, counties, municipalities and regional universities for whom active employees do not participate in the Commonwealth's Public Employee Health Insurance Program, were 56% higher than that of other Commonwealth Group members. In aggregate, the 8,862 CERS and regional university retirees and their dependents that participate in the Commonwealth Group added $9.9 million in excess cost that was absorbed by the Commonwealth and other Commonwealth Group members in calendar year 2000.
- The claims experience of COBRA beneficiaries covered under the Commonwealth's Public Health Insurance Program's in 2000 strongly illustrates that when individuals are allowed to "buy into" a group health insurance program, their claims cost will be substantially higher than the average of the group overall. In 2000, the average claims cost of COBRA members was over 2 ½ times that of the remainder of the Commonwealth Group. This type of impact is also likely if groups are allowed to enter and exit the Commonwealth Group at will or other individuals were allowed to voluntarily join the Commonwealth Group.
- Risk adjustments based on the age, gender or health status of the individuals who enroll in a particular healthcare option are controversial, since they result in premium adjustments after individuals have selected the health plan in which they wish to enroll. Additionally, some insurers could legitimately argue that the segment of the Commonwealth Group enrolled in the plans they insure has a better health status profile due to their efforts with respect to preventive care or the management of care for individuals with chronic health conditions. Based on the age and gender of Commonwealth Group members enrolled in each insurer's plans as of February 2001, the expected cost differential between the insurer covering the group with the lowest expected healthcare cost and the insurers covering the groups with age and gender characteristics that would be expected to generate the highest healthcare cost is only 5.3%.

Self Funding

Description

Employee health insurance programs for which the sponsoring employer assumes the financial risk for the cost of medical services received by plan participants (claims) are termed "self-funded" programs. The liability assumed by a self-funded group includes all claims actually paid during a Plan Year, as well as those claims incurred during the year but not yet paid as of the last day of the Plan Year.

Under a self-funded arrangement, the risk for claim fluctuations, both positive and negative, would be transferred from the health plans that currently insure the Commonwealth's Public Employee Health Insurance Program to the Commonwealth, except as may be limited through the purchase of some form of stop-loss insurance. Additionally, unless fiduciary responsibility is delegated to a third party administrator (TPA), the Commonwealth would ultimately be responsible for decisions involving claim payments and other administrative determinations associated with the program.

Although it is far more common for indemnity and PPO plans to be self-funded than HMO options, self-funding is *not* limited to indemnity and/or PPO style plans. HMO and POS plans may also be self-funded, particularly for larger groups in health plans where few, if any, services are capitated. (For information regarding self-funding prevalence in other state healthcare programs, please see Funding Arrangements under Other State Programs.)

Advantages and Disadvantages

Key advantages and disadvantages of self-funding are outlined below.

Advantages

- When claims are less than projected, the self-funded plan (or the employer) benefits rather than an insurance carrier.
- In the early months of a self-insured arrangement (the terms "self-funded" and "self-insured" may be used interchangeably), claims incurred prior to the effective date of self-funding are paid from the prior insured plan's reserves. This results in an immediate cash flow advantage to the self-insured plan, which should be the source for establishing a reserve for claims incurred but not yet paid.
- In addition to the cost of medical services received by plan participants, both insured and self-funded plans incur administrative expenses for claims payment and other administrative services necessary to operate the plan. However, administrative expenses under a self-funded arrangement are typically lower due to the elimination of insurer risk charges that are normally 2-5% of total premiums. Additionally, assuming that claim reserves are invested by the self-funded plan, the interest earned on these reserves will likely exceed the interest credits, if any, included in the insured plans' rate determinations.
- A higher percentage of prescription drug formulary rebates, usually 2-3% of pharmacy claims or .4% to .6% of total claims, are normally credited to the plan sponsor under a self-funded arrangement than under an insured arrangement.

- A self-funded program may have more negotiation flexibility with providers. Through direct contracting, a self-funded program may be able to include more providers in the plan's network, albeit at a higher cost to the plan.
- A self-funded program typically has more design flexibility. For example, a self-funded employer can offer options with HMO style benefits in areas where HMOs do not exist. This may result in more consistency in the benefit options offered to plan participants in different geographic areas of the Commonwealth.
- Currently, the Commonwealth's health insurance risk pool is split among five insurance carriers, segmenting its risks based on plan availability by geographic area and individual employees/retirees' selections. Under a self-funded arrangement, the Commonwealth could consolidate its risk pool and have increased flexibility in allocating its healthcare program's costs.
- By self-funding, employers increase their ability to carve out segments of their healthcare program, like pharmacy benefit management or behavioral health services, to customize the program to meet its specific requirements. Through these carve out arrangements, greater consistency in plan administration, including items like prescription drug formulary changes, may be achieved.

Disadvantages

- The financial risk an employer assumes is the biggest drawback to self-funding. In a self-funded arrangement, if claims and expenses exceed projections, it is the employer that must absorb the deficit. Given the magnitude of the Commonwealth's healthcare program's total expenditures, if claims and expenses exceeded projections by only 5%, a deficit of over $30 million would result. This level of variance or more is possible, particularly in the first year of self-funding due to the number of changes that are likely to occur in:
  - Provider network composition and therefore charges and practice patterns;
  - Provider reimbursement arrangements, if networks change; and
  - Claims and care management, if vendors managing the program change.

  Additionally, in periods of increasing healthcare trends, as is the case currently, there is a greater probability that actual costs will deviate from projected costs.
- It is essential to establish and maintain adequate claim reserves to properly fund a self-insured plan's obligations. Any pressure to use healthcare program reserves for other purposes must be resisted if the program is to be financially sound. If reserves reach excessive levels, careful management is required to maintain stability in employee contribution amounts, particularly given that the Commonwealth does not currently explicitly subsidize the cost of dependent healthcare coverage.
- Under a self-funded arrangement, the Commonwealth may not be able to duplicate the current provider networks in place. If this occurs, the relationship between a patient and his/her healthcare provider(s) may be disrupted.
- While self-funding may increase the Commonwealth's flexibility in negotiating with healthcare providers and the options offered to its members, this flexibility could result in increased health plan costs for the Commonwealth and its employees/retirees.
- Insured plans resolve contested or unusual claims and act as a third-party buffer for the employer. Unless the Commonwealth delegates fiduciary responsibility for claim

determinations and payments to the third party administrator, under a self-funded arrangement, the Commonwealth would be faced with making these determinations. Claim denials may be directly attributed to the Commonwealth and have the potential for causing increased employee dissatisfaction or increased pressure to pay ineligible expenses, thereby increasing plan expenditures. Additionally, legal actions taken by plan members could include the Commonwealth.

- The Commonwealth's current program structure supports regional health plans for which the Commonwealth Group comprises 70% or more of some plans' enrollment. In aggregate, the Commonwealth Group comprises about 20% of the health insurance market in Kentucky.[18] As some of these organizations are not postured to operate in a self-funded environment, if the Commonwealth were to self-fund the Commonwealth's Public Employee Health Insurance Program, it could adversely impact the health insurance market for all Kentucky health insurance consumers.

Other Considerations

In addition to the advantages and disadvantages outlined above, the Commonwealth should consider the following in reaching a decision whether to self-fund its employee healthcare program:

- Actuarial assistance will be required to establish funding rates (pseudo premium rates) that can be expected to cover the claims paid by the health plan and administrative expenses of the plan and to establish adequate reserves for claims incurred but not yet reported or paid by the plan.
- Many self-funded health plans obtain stop-loss coverage to limit their maximum liability. Stop loss coverage is basically insurance that covers expenses above a specified amount, either for each covered individual (specific coverage) or for the plan as a whole (in aggregate). However, given the size of the Commonwealth Group, it is anticipated that the premiums paid for stop loss coverage would exceed any reimbursements received from the insurance carrier.
- When self-funded, a health plan becomes subject to Internal Revenue Code Section 105(h) non-discrimination rules. Given the current structure of the Commonwealth's Public Employee Health Insurance Program, this should not create a problem. However, this provision would need to be considered if any revisions to the plan were considered that would discriminate in favor of highly compensated employees as defined by Section 105(h). It also would need to be taken into account if the Commonwealth becomes involved in decisions as to whether to cover questionable expenses under the plan for highly compensated individuals or their family members.
- Reserves must be established and maintained in a sufficient amount to cover medical services that have been received but for which payments have not yet been made. This requirement is addressed in more detail in the section titled *Funding Requirements* which follows.
- Perhaps most importantly, the Commonwealth would need to assume responsibility for new functional requirements. These requirements and associated staffing implications are outlined in the section titled *Staffing Requirements*.

[18] *Department of Insurance*

Funding Requirements

Reserves must be established and maintained in a sufficient amount to cover medical services that have been received but for which payments have not yet been made. Care must be taken to maintain reserves at an adequate but not excessive level. Based on the experience reported by the Commonwealth's insurance carriers, this reserve would need to be about 18-20% of paid claims or around $100 million for calendar year 2002.

In years when the reserves held exceed needed levels (surplus) or are below the required amount (deficit) careful consideration will be needed in determining how to spend down the surplus or fund the deficit, including how individual entities that participate in the Commonwealth Group will be affected. The rates required to fund claims and expenses for future periods should be developed based on expected future claims and expenses irrespective of reserve deficits or surpluses. To the extent possible, reserve surpluses and deficits should be addressed independently of future funding rates.

If reserve surpluses are taken into account in establishing funding rates for a period, and experience develops as expected, funding rates for the subsequent period would need to be increased by both the surplus taken into account for the current period and expected inflation. If they are not, a deficit will result in the subsequent period. This is similar to the experience of Kentucky Kare in the years following 1993 when policymakers decided to place a moratorium on premium increases until its reserves were reduced.

If reserve deficits are taken into account in establishing funding rates for a period, and experience develops as expected, the funding rate increase for the subsequent period would be offset by the deficit recouped in the current period. This may result in sea-sawing medical rates. This is illustrated by the following example:

- Suppose projected costs for 2002 were $500 million based on an aggregate, annual funding rate of $5,000 for 100,000 enrollees. However, actual expenses for 2002 were $600 million, generating a deficit of $100 million or 20%.
- Assuming medical inflation of 10% from 2002 to 2003, the projected composite annual rate, including full deficit recoupment, would be $7,600 for 2003 – $6,600 to fund expenses expected to be incurred in 2003 ($6,000 x 110%) plus $1,000 to fund the deficit ($100 million divided by 100,000 enrollees). In essence, funding rates would have increased 52% from 2002 to 2003.
- If actual expenses for 2003 were $660 million as expected and medical inflation was expected to be 10% from 2003 to 2004, the 2004 composite annual funding rate per enrollee would be $7,260 ($6,600 x 110%), a reduction of about 4.5%.
- If actual expenses in 2004 were $726 million as expected, the composite annual funding rate for 2004 would need to increase by the expected medical trend from 2004 to 2005. It this were 10%, the annual funding rate per enrollee would increase 10%.

Staffing Requirements

Under a self-funded arrangement, the Commonwealth would need to assume responsibility for new functional requirements that are not present today:

- establishing and maintaining a "fund" to hold reserves;

- setting up banking procedures for remittance of administrative expenses and claim payments to the third party administrator(s) the Commonwealth selects to pay its healthcare claims; and
- implementing centralized facilit(ies) to determine the "premiums" due each month from each entity participating in the Commonwealth's Public Employee Health Insurance Program, collecting "premiums" from each entity, reconciling premiums received with each entity's eligibility information, remitting monthly payments for administrative expenses and weekly or daily payments for claims to the Commonwealth's third party administrator(s), and reconciling the balance in the reserve fund.

New procedures would need to be established and additional staffing obtained to support these additional functional requirements.

Findings

- The majority of other states (72%) self-fund at least one of their health insurance options. However, only 15% self-fund their entire health insurance program.
- The Commonwealth's insured funding arrangement is consistent with other states in view of the plan types it offers to employees and the heavier concentration of Commonwealth Group members enrolled in HMOs.
  - Seventy-six percent of other states responding to the Commonwealth's survey insure all of their HMO offerings. Another 12% insure some of their HMO offerings and self-fund other HMO options. Only 12% self-fund all of their HMO offerings.
  - For POS and PPO options, other states are split roughly in half regarding their funding arrangement – insured vs. self-funded.
- The advantages and disadvantages of self-funding are outlined in the following table.

Exhibit XXXI

Self-Funding Advantages and Disadvantages	
Advantages	**Disadvantages**
▪ Lower expected administrative costs ▪ Larger formulary rebate credits ▪ Negotiation flexibility ▪ Design flexibility ▪ Cost allocation flexibility ▪ Customization ability ▪ Potential for increased consistency	▪ Risk assumption – deficit potential ▪ Reserve management ▪ Patient/provider disruption potential ▪ Unavailability of some plan choices ▪ Loss of third party buffer ▪ Impact on Kentucky insurance market ▪ Potentially, increased claim costs due to negotiation/design flexibility ▪ Additional Commonwealth staffing required

Source: William M. Mercer, Incorporated

Healthcare TPA and Vendor Evaluation Strategies

Third party administrators and other health plan vendors can be evaluated in many different ways. These fall into four primary categories:

- written proposals,
- oral presentations,
- on-site reviews, and
- audits.

Each of these is discussed with its inherent limitations and advantages below.

Written Proposals

Historically, the Commonwealth has issued a Request for Proposal (RFP) to organizations interested in insuring the Commonwealth Group or in administering the healthcare benefits provided to Commonwealth Group members. Proposal responses are evaluated by an evaluation committee. Technical proposal responses are scored first. Once technical responses are scored, cost proposals are scored. These two components are then combined to determine the vendor(s) best qualified to provide healthcare coverage to Commonwealth Group members.

For calendar year 2002, the criteria used to score vendors' proposals were:

Exhibit XXXII

Commonwealth's 2002 Health Insurance RFP Scoring Criteria	
Financial Strength	Pass/Fail
Network Requirements ▪ Hospital – the provider network must have at least one hospital in every county bid where a hospital exists ▪ Physicians – the provider network must have at least 25% of the largest number of physicians in any bidder's provider network for a county	Pass/Fail by County
Administrative Strength	5%
Customer and Claims Service	10%
Managed Networks	30%
Medical Management and Quality Assurance	15%
Cost	30%
Offering in Under Served Counties	10%

Source: Commonwealth Group 2002 Health Insurance RFP

For qualitative technical questions, bidders' responses were summarized side-by-side. From this comparison, pros and cons were identified for each bidder. Taking these results into account, the evaluation team then assigned evaluation points.

Other technical questions and cost proposals were evaluated on a quantitative basis. For the technical proposal component, the following provider network features were evaluated on a quantitative basis, separately for each county in the Commonwealth:

- Physician breadth – the number of physicians (M.D.s and D.O.s) that participate in the health plan's provider network in a given county, or in the case of counties where there are fewer than 20 physicians, based on the number of physicians in the health plan's network in the region (per the Medicaid region definition) and/or county and region.
- Hospital breadth – the number of hospitals in the health plan's provider network in the county and region being evaluated.
- Behavioral health provider breadth – the number of behavioral health providers that participate in the health plan's provider network.
- Pharmacy breadth – the number of pharmacies that participate in the health plan's provider network in a given county.
- Provider accessibility – the percentage of Commonwealth Group members in a specific county that are within 30 miles of two primary care network physicians (PCPs) and one network hospital; the percentage that are within 15 miles of 2 PCPs and one hospital; and the average distance that Commonwealth Group members must drive to reach five primary care physicians.
- Plan types offered – the number of plan types (HMO, POS and PPO) offered by a bidder in a given county.

Cost proposals for insured scenarios were evaluated based on the insured rates quoted. For the self-funded scenarios, administrative fees and provider reimbursement arrangements were utilized to develop projected funding rates to evaluate the expected level of cost for each bidder.

Finally, bidders who offered coverage in counties where there are fewer than 3 carriers in 2001 received credit for offering in under served counties. The credit was doubled for offering in counties with only one carrier choice in 2001. This credit was applied to the bidder's score in every county in which it bid. Therefore, bidders who offered coverage in under served counties improved the likelihood that they would be selected in counties where more than 3 bids were received (the number of bidders selected in a given county for 2002 was limited to a maximum of three).

Up to three insurance carriers per county were selected to offer coverage to Commonwealth Group members, based on the scores assigned by the evaluation committee to their written technical and initial written cost proposal. Following the selection of the carriers to be offered in each county, the Commonwealth held face-to-to meetings with each selected carrier to negotiate final premium rates and other provisions.

While written proposals provide a forum to gather quantitative data, they are more limited in their ability to capture qualitative information. Furthermore, as only written information is evaluated, there is the possibility for misinterpretation and missing information.

Oral Presentations

To address some of the limitations of evaluations based on written proposals, some health plan sponsors use oral presentations/bidder interviews to seek clarification of written proposals and

obtain more qualitative information. Typically, individual meetings are held with each bidder for this purpose. Interview findings are summarized by the evaluation team and written proposal scores adjusted if warranted.

While oral presentations/interviews allow for better collection of qualitative data and the ability to clarify information regarding vendors' capabilities, they still depend heavily on representations made by bidders. To validate bidders' responses, plan sponsors sometimes perform on-site reviews.

On-Site Reviews

On-site reviews are another method of evaluating third party administrators and other healthcare vendors. These can be used to supplement and validate proposal responses prior to selection of a healthcare vendor, to identify implementation risk factors once a vendor is tentatively selected, or to evaluate an incumbent vendor's performance.

On-site reviews can be classified into three main categories:

- Implementation,
- Operational, and
- Customer service.

The purpose of implementation reviews is typically to identify risk factors when a new third party administrator, new insurance carrier or new funding arrangement is being implemented. These usually involve thorough testing of the eligibility and claim processing systems to ensure that they are set up to meet the plan's requirements.

Operational reviews may encompass:

- an assessment of the vendor's staff to determine if adequate staff are available to provide timely services – additionally, this component of the review also takes into account staff experience and training to determine whether the staff have the appropriate qualifications to provide quality services;
- a review of systems to identify any potential shortcomings and workarounds necessary; and
- an evaluation of policies and procedures.

Customer service reviews use targeted questionnaire responses to identify potential strengths and weaknesses. This information is enhanced by an evaluation of the structure of the customer service unit, silent monitoring of telephone calls, and an assessment of open call volumes, call documentation and management.

Audits

On-site audits are a key method used to evaluate the performance of incumbent health care vendors and insurance carriers. Audits typically fall into one of two major types: claims and eligibility or clinical. Claims and eligibility audits can be used to validate vendor reported results in relation to performance guarantees. These can be performed based on a statistical sampling or a full electronic audit of all claims paid for a period. Statistical claims and eligibility audits generally encompass as assessment of: claim processing turnaround, financial accuracy,

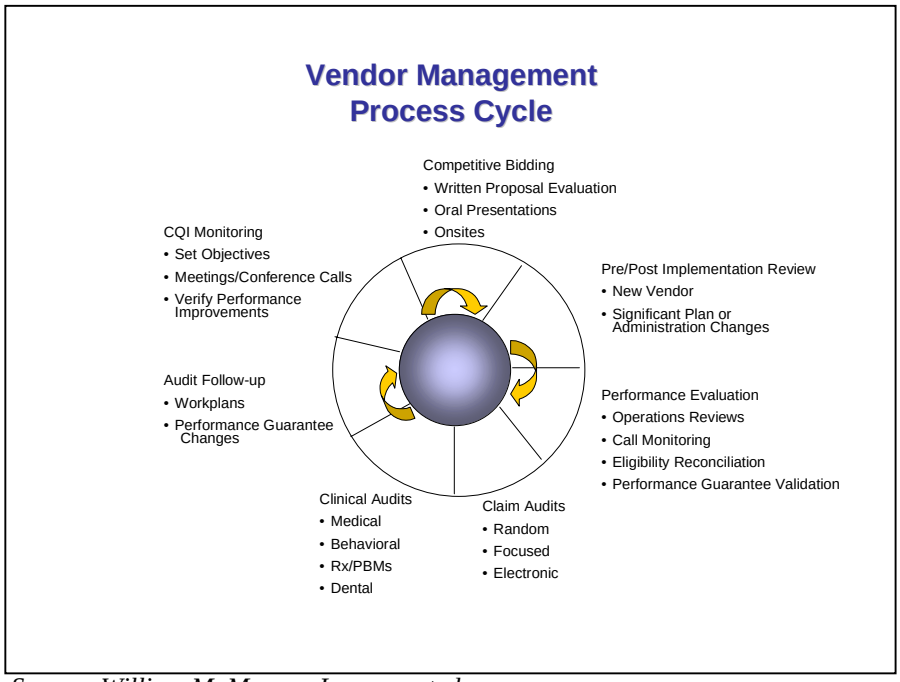
and coding accuracy. Electronic audits place more emphasis on validating financial claim payment accuracy.

Clinical audits focus on the utilization and care management aspects of the health plan. Clinical professionals review patients' charts to ascertain the efficacy of the utilization and care management processes applied to actual claims. Additionally, the care management staff, processes and procedures are benchmarked against best practices.

Ongoing Management

On an ongoing basis, regular meetings or conference calls can be used to review ongoing and emerging issues. Additionally, vendor progress against their documented work plan and performance measures should be monitored. And, focused claim reviews can be applied where appropriate. A sample process cycle is illustrated below.

Exhibit XXXIII



Source: William M. Mercer, Incorporated

Commonwealth Approach To-Date

To-date, the Commonwealth has used written proposals to evaluate health insurance vendors for the Commonwealth's Public Employee Health Insurance Program. To encourage carriers to provide good quality service to Commonwealth Group members, OPEHI, and its benefit coordinators, the Commonwealth has incorporated performance guarantees in its health insurance contracts, with monetary penalties if performance standards are not met. OPEHI receives periodic reports from each of the Commonwealth Group's insurance carriers outlining their performance in relation to the performance guarantees to which they agreed. OPEHI holds meetings and conference calls with the Commonwealth Group's insurance carriers as necessary for continuous quality improvement. The performance standards for plan year 2001 and applicable penalties, if these standards are not met, are summarized below.

2001 Performance Standards[19]

Enrollment / Eligibility

If performance statistics indicate that any of the following standards are not met during a quarter, liquidated damages up to an annual maximum of $8 per contract will be assessed.

- Timeliness of ID Card distribution – 95% issued for receipt by effective date (assumes clean eligibility data received 21 calendar days prior to effective date). Penalty if standard not met - $0.50 per contract per quarter.
- Accuracy of ID Cards – 95% or better. Percent of employees calling with problems requiring re-issue – less than 2%. Penalty if standard not met - $0.50 per contract.
- Informational packets, including provider listing by county and map identifying product availability by county, to be mailed to all employees and retirees prior to open enrollment. Penalty if standard not met - $1.00 per contract.
- Certificates of Coverage mailed to members' homes within 30 days of effective date. Penalty if standard not met - $0.50 per contract.

Reporting

If any one of the following reporting standards are not met during a quarter, liquidated damages equal to a maximum of $3.00 per contract will be assessed.

- Monthly reports to be delivered by the 30th of the following month. Penalty if standard not met - $0.50 per contract for each business day over the standard.
- Quarterly Reports to be delivered within 30 calendar days from the end of the quarter. Penalty if standard not met - $0.25 per contract for each business day over the standard.

Claims

- Claims processing turnaround time – first 95% of claims paid within 30 calendar days. Penalty if standard not met - $2.00 per contract per quarter.
- Financial accuracy – 97%. Penalties range from $2.00 to $3.00 per contract per quarter, depending on financial accuracy percentage.

[19] *OPEHI*

- Claims payment accuracy – 97%. Penalties range from $2.00 to $3.00 per contract per quarter, depending on the claims payment accuracy percentage.

Data Transfer

If performance statistics indicate that the following standard is not met during the quarter, liquidated damages equal to a maximum of $5.00 per contract will be assessed.

- 99% of all error transactions corrected within two business days of receipt of the error reports obtained from the Commonwealth and/or internally generated.

Findings

- A summary of the four primary methods employer health plan sponsors use to evaluate healthcare vendors and their strengths and weaknesses is provided in the following chart:

Exhibit XXXIV

Pros and Cons of Primary Healthcare TPA and Vendor Evaluation Methods

	Strengths	Weaknesses
Written Proposals	• Written offer • Allows for collection of a great amount of quantitative data	• Limited in ability to capture qualitative information • Possibility for misinterpretation • No validation of vendor representations
Oral Presentations	• Allows for better collection of qualitative information than written proposals • Provides ability to clarify vendors' capabilities	• Depend heavily on vendor representations • No written offer if not coupled with written proposal • Limited in ability to collect quantitative data unless coupled with written proposal
On-Site Reviews	• Allows for verification of vendor representations • Allows for in-depth assessment of vendor's staff and systems	• Time and expertise required to conduct on-sites
Audits	• Allows for verification of vendor representations	• Time and expertise required to conduct audits

Source: William M. Mercer, Incorporated

- To-date, the Commonwealth has used written proposals to evaluate health insurance vendors for the Commonwealth's Public Employee Health Insurance program. Additionally, insurance carriers' reported results in relation to contractual performance guarantees and periodic meetings are used by OPEHI to manage the Commonwealth's Public Employee Health Insurance vendors.

Summary of Findings

This section provides a consolidated summary of the key findings presented in the previous sections of this report. The Board's recommendations, based on these findings, are outlined in the Executive Summary of this report.

Commonwealth Public Health Insurance Program Costs and Benefits

Like other employers, the Commonwealth will be challenged to control increases in the cost of the Commonwealth's Public Employee Health Insurance Program, particularly prescription drug costs. However, Commonwealth employees and retirees expect the Commonwealth to maintain the current level of health insurance benefits, or at least continue to provide health insurance benefits comparable to those provided by other states to their employees. Maintaining current benefit levels in the future with affordable employee premiums, without substantial increases in the Commonwealth's funding, will be difficult at best.

Costs

In 2000, Commonwealth Group healthcare claims increased at a faster pace than the national average of 8.1%. However, the increase was in line with that of South region employers, whose healthcare program expenses grew 11.1%. To-date the following cost drivers have been identified in the Commonwealth's Public Employee Health Insurance Program:

- While overall healthcare claims for the Commonwealth Group increased 11.5% per covered life from 1999 to 2000, prescription drug expenditures in the Commonwealth's Public Employee Health Insurance Program grew 17.9%
- An in-depth analysis of the Commonwealth Group's prescription drug experience in 1999 and 2000 indicates that costs within the Commonwealth's Public Employee Health Insurance Program are increasing due to several factors:
  - an increase in unit price for the same service, supply or prescription drug,
  - a change in the mix of services, supplies, or prescription drugs received by Commonwealth Group members,
  - co-payment leveraging – the impact of fixed dollar co-payments on a health plan's cost in relation to unit price increases, and
  - an increase in the number of services, supplies or prescriptions received.
- In general, healthcare costs increase with age. The average healthcare claims for an individual between the ages of 50 and 54 are over 35% higher than for individuals between the ages of 45 and 49 and 57% higher than for those age 40 to 44. Therefore, the growth of covered retirees as a percentage of the Commonwealth Group will present a challenge to efforts to maintain affordable healthcare benefits, especially in a period of escalating healthcare costs. This is compounded by the inclusion of CERS and regional university retirees for whom the corresponding active groups do not participate in the Commonwealth's Public Employee Health Insurance Program.
- Health insurance premiums increased at a higher rate in 2000 (14.8%) than the actual claims paid to healthcare providers for services received by Commonwealth Group members (11.5%). Potentially, this may be a result of:
  - higher operating expenses within the Commonwealth's insurance carriers;

- a desire for higher profits from its carriers;
- insurance carriers' propensity to use conservative trends in projecting healthcare costs for groups they insure, particularly in a period of increasing trends;
- and/or conservative projections by the Commonwealth's insurers due to the segmentation of the Commonwealth Group's risk pool among up to three carriers per county.

Other factors that impact the Commonwealth Group's costs or benefit offerings are:

- Forfeitures from Commonwealth funds contributed to healthcare flexible spending accounts of Commonwealth Group members who waive health insurance coverage through the group could amount to $17 to $19 million in 2001. While KRS 18A.225(2)(g) provides that these forfeitures shall be transferred to the credit of the state health insurance plan's appropriation account, the current budget overrides the application of KRS 18A.225(2)(g) with respect to school boards, the largest segment of the Commonwealth Group.
- KRS 18A.227(4) precludes any individual employed under KRS Chapter 16, KRS Chapter 18A, or KRS Chapter 151B from receiving the state healthcare contribution as an active employee if the individual is also eligible for and elects to participate in the Commonwealth's Public Employee Health Insurance Program as a retiree, or the spouse of a retiree, under any of the Kentucky Retirement Systems. However, there are still individuals who receive more than one state healthcare contribution.
- Although the model procurement code operates well for other Commonwealth purchases, its application to the purchase of health insurance may create unintended consequences. For example, if the Commonwealth needs additional carriers in certain areas, and, during negotiations, an insurance carrier is willing to expand its proposal to include those areas, the carrier cannot adjust its bid to account for the risks and costs of these areas. Consequently, the opportunity to add plan choices in under served areas may be rebuffed by carriers. The Office of Public Employee Health Insurance (OPEHI) and the Department of Administration are working jointly to study this issue.

Benefits

In relation to other states' employee healthcare programs:

- The Commonwealth's Public Employee Health Insurance Program differs from that of other states in the groups that are covered. The majority of other states cover university employees while only regional university ***retirees*** are members of the Commonwealth Group. Although part of the Commonwealth Group, less than half (42%) of other states cover teachers and health board employees. Most importantly, ***retirees of local governments*** are members of the Commonwealth Group. Only 24% of other states indicated that they cover local government actives or retirees.
- The Commonwealth offers a choice of more healthcare options to Commonwealth Group members than most other states.
- Thirty percent of other states offer an indemnity healthcare option to all their employees. An additional 6% offer an indemnity option to out-of-state employees/retirees. The Commonwealth does not offer an indemnity option.
- Although the Commonwealth offers PPO options with the same benefit provisions in 115 of 120 Commonwealth counties, and an EPO C option with consistent benefit provisions

statewide, employee contributions for these options vary based on the insurance carrier(s) willing to offer coverage in each county. Unlike the majority of other states (88%), the Commonwealth does not offer a consistent healthcare option statewide.

- Although some of the co-payments in the Commonwealth's options are higher than the median reported by other states, actuarially, the Commonwealth's HMO A option is around 98% of the value of the median HMO option offered by other states. The actuarial value of the Commonwealth's POS A option is within ½% of the value of the median POS option offered by other states, and the Commonwealth's PPO A option is within 6% of the value of the median PPO option offered by other states.
- Almost 80% of other states offer a mail order prescription drug feature within their employee healthcare program. This provision is not currently included in the Commonwealth's Public Employee Health Insurance Program. When structured properly, both the health plan and its members save valuable prescription drug dollars when a mail order pharmacy feature is included. Members typically pay lower co-payments and receive the added convenience of ordering and receiving prescription drugs at their homes. For example, an employee or retiree who currently purchases 48 maintenance brand name prescriptions annually would pay $720 in prescription drug co-payments under the Commonwealth's Public Employee Health Insurance Program A options. If a mail order option were incorporated, with 90 days of medication available for 2 retail co-payments, the employee/retiree would pay only $480 in co-payments for these same prescriptions, saving $240 annually, or 33% of the cost of his/her maintenance prescriptions.

  A health plan's mail order savings varies based on its underlying reimbursement arrangements for both retail and mail prescriptions, drug mix, and utilization. In general, it is estimated that a plan like the Commonwealth's could save up to 1% of prescription drug costs for every 10% of prescriptions that are filled via mail, if a mail order pharmacy provision were added where the mail order co-payment for a 90-day supply of a maintenance drug is 2 times the retail co-payment for a 30-day supply of the same drug.
- For HMO and PPO options, the Commonwealth's average total single Option A premium rate is within 2% of the average reported by other states. The Commonwealth's average POS Option A premium rate is 26% higher than the average reported by other states. This difference can be explained, at least in part, by a substantial difference in retiree POS enrollment between the Commonwealth Group (25%) and other states (4%).
- The most striking difference between the Commonwealth's healthcare program and that of other states is the state's contribution strategy.
  - The majority of other states (88%) subsidize the cost of dependent healthcare coverage. Of these, 83% require employees to pay a portion of individual healthcare coverage premiums. The Commonwealth does not directly subsidize the cost of dependent healthcare coverage and pays the full cost of single coverage for the lowest cost Option A in each county.
  - Few states (11%) provide an alternative benefit to individuals who waive healthcare coverage. The Commonwealth's healthcare flexible spending account waiver benefit is almost double that of any other state. However, data from the other states indicates that the vast majority of individuals currently waiving healthcare coverage through the Commonwealth would enroll in a state sponsored healthcare option if the Commonwealth's FSA waiver contribution were eliminated entirely.

- While the majority of states (72%) sponsor at least one self-funded plan, only 15% self-fund their entire healthcare program. The Commonwealth's insured funding arrangement is consistent with other states in view of the plan types it offers to employees and the heavier concentration of Commonwealth Group members enrolled in HMOs.
- Like other states, the Commonwealth extends healthcare coverage to early retirees. However, it appears to be unique in covering some retiree groups for which the corresponding active group does not participate in the Commonwealth's program. In general, the Commonwealth's pre-65 retiree healthcare coverage is more generous than that of most states.

Dependent Subsidies

The Commonwealth implicitly subsidized dependent healthcare costs by about $7.6 million in 2000 by virtue of:

- the relationships established between its single and dependent coverage premium rates, and
- the application of a portion of the Commonwealth's fixed dollar health insurance contribution to dependent health insurance premiums by Commonwealth Group members who elected health insurance options where the single coverage cost was less than the Commonwealth's fixed dollar contribution.

However, as the Commonwealth does not explicitly subsidize any portion of dependent health insurance premiums, Commonwealth Group members' dependent healthcare premiums are substantially higher than the average of other states. In comparison to other states, which typically pay 50% or more of the cost of dependent healthcare coverage, Commonwealth Group members' dependent healthcare premium contributions are:

- 50% higher for Parent+ coverage than the average of other states, and
- 2.6 times the average employee contribution for Couple and Family coverages.

Without a direct dependent health insurance premium subsidy, Commonwealth Group members will continue to be faced with substantially higher contributions for dependent healthcare coverage each year. As occurred in 2000, likely due to the magnitude of Commonwealth Group dependent healthcare premium increases from 1999 to 2000, the lack of dependent healthcare premium subsidies may result in a continual decline in the number of employees/retirees electing dependent healthcare coverage through the Commonwealth's Public Employee Health Insurance Program. However, the Employee Advisory Committee has advised the Board that it does not want the Commonwealth to deviate from its current policies of:

- paying the full cost of single health insurance coverage under the lowest cost Option A available in each county, although the majority of other states that subsidize the cost of dependent healthcare premiums (83%) require employees to pay, on average, $34 per month in 2001 for single healthcare coverage; or
- providing a healthcare flexible spending account benefit, at a level comparable to the value of the single healthcare coverage option funded by the Commonwealth, to Commonwealth Group members who choose to waive health insurance under the Commonwealth's Public Employee Health Insurance Program, even though few states (11%) provide an alternative benefit to individuals who waive healthcare coverage and the Commonwealth's waiver benefit is almost double that of any other state.

If dependent subsidies were implemented by the Commonwealth, without any offsetting changes in the Commonwealth's Public Employee Health Insurance Program, the additional estimated annual cost ranges from roughly $38 million, if the Commonwealth paid 25% of dependent healthcare premiums, to $446 million, if the Commonwealth paid 100% of dependent premiums. As premium contributions affect employees' healthcare elections, enrollment changes had to be estimated in order to project costs under various dependent subsidy alternatives. As actual enrollment may differ from the expected enrollment used in the cost projections, actual costs may vary from estimated costs by as much as 20%. Furthermore, these cost estimates are based on February 2001 Commonwealth Group enrollment and premiums. The additional Commonwealth cost to subsidize dependent healthcare premiums will increase annually at the same rate as the employee healthcare premiums paid by the Commonwealth.

Due to the magnitude of employee premium contributions for dependent health insurance, the Board researched options to fund a dependent premium subsidy. These included:

- Reducing the Commonwealth's contribution for single health insurance from 100% to 90% of the cost of the lowest cost Option A available in each county. This option would have generated funding of about $27 million in 2001.
- Reducing the Commonwealth's contribution to the healthcare flexible spending accounts of individuals who waive health insurance through the Commonwealth Group, in conjunction with recouping FSA forfeitures from all entities participating in the Commonwealth Group. These two steps would have generated around $38 million in aggregate in 2001.
- Requiring groups whose retirees participate in the Commonwealth Group, but whose active employees do not, to pay the additional cost for their retirees, approximately $10 million.

In total, these options would have generated about $75 million in 2001, enough to fund up to 35% of dependent health insurance premiums. However, while the Employee Advisory Committee has recommended that the Commonwealth subsidize the cost of dependent health insurance premiums, it is not in favor of the Commonwealth either:

- reducing its contribution for single health insurance coverage, or
- reducing its contribution to the healthcare flexible spending accounts of individuals who waive health insurance through the Commonwealth Group

as a means to fund dependent health insurance premium subsidies.

Adverse Selection and Risk Adjustment

Adverse selection results whenever individuals are offered a choice of health plan options. Adverse selection is the additional cost that results when an individual selects the plan that minimizes his/her out of pocket expenditures, and thereby maximizes the plan's cost.

There are several factors that can influence the cost resulting from selection. These include:

- the differential between the provisions in the various plan options offered;
- the composition of the provider network available for each plan option;
- the level of contributions that employees and retirees must pay to enroll in each healthcare option and level of coverage (single, couple, parent+, family);

- whether the group is consolidated under a single risk arrangement or it is divided into separate risk pools, for example with different insurance carriers;
- the ability for groups that comprise the aggregate group to enter or exit the group arrangement or for individuals to elect to join the group/continue coverage through the group; and
- how premium rates are established between various plan options and levels of coverage.

Past selection issues identified and addressed in the Commonwealth's Public Employee Health Insurance Program, selection issues that still exist within the program, and those that might result from legislation proposed in the past are summarized in the following.

Past Selection Issues and Mitigation Efforts To-Date

Prior to 1999, under the Health Purchasing Alliance, insurance carriers were allowed to independently determine the premium rate relationships between single and dependent coverage levels. These varied substantially among the participating insurance carriers. In some cases, the Family premium rate was less than the Couple rate. This was likely because of a desire of the insurance carriers offering coverage under the Purchasing Alliance to attract the best risks, as those individuals electing Couple coverage are likely to be older empty-nesters, while those electing Family coverage are likely younger. (This is supported by the Commonwealth Group's 2000 enrollment. In 2000, spouses of those Commonwealth Group members electing Couple coverage were, on average, 10 years older than spouses of the Commonwealth Group members electing Family coverage.) When the Personnel Cabinet took over responsibility for the Commonwealth's Public Employee Health Insurance Program in 1999, it eliminated this selection factor by establishing required relationships between dependent coverage premium rates and the single coverage rate.

The Commonwealth offers employees and retirees two HMO, two POS and two PPO options. The A options provide higher benefit levels, and therefore have higher premium costs. The B options have lower benefit levels, and therefore, lower premium costs. When a choice of high and low options is offered to individual health plan participants, it is common for those individuals with lower healthcare costs to select the lower cost healthcare option (i.e. option B). This typically results in a lower loss ratio, a greater difference between the premium charged and the claims paid, and therefore more money for operating expenses and/or profit for the insurance carriers insuring a larger segment of option B plan participants. In analyzing the premium rates established by insurance carriers for the Commonwealth's Public Employee Health Insurance Program for 1999, 2000 and 2001, the Commonwealth noted that the differential between the option A and option B premium rates varied substantially by carrier and fluctuated from year to year. To mitigate the potential selection resulting from this practice, effective with the 2002 plan year, the Office of Public Employee Health Insurance stipulated a permitted range for the differential between the Option A and Option B rates for a given plan type (HMO, POS or PPO).

The amount providers charge for various healthcare services varies between different geographic areas within the Commonwealth. To blend these low and high cost areas, thereby equalizing, to the degree possible, employee contributions for dependent coverage, the Commonwealth requires insurance carriers to charge the same premium for the same plan type and option in all counties where they offer coverage to Commonwealth Group members. This is consistent with the provision in KRS 18A.225(2)(c), enacted by the 2000 General Assembly under Senate Bill 288, that requires insurance carriers to rate all members of the Commonwealth Group, other than

retirees whose former employees insure their active employees outside the Commonwealth Group, as a single entity.

Current Selection Issues

Retirees of regional universities and cities, counties, and municipalities within the Commonwealth that participate in a state-sponsored retirement program participate in the Commonwealth's Public Employee Health Insurance Program. However, most of the active employees of these entities do not. In 2000, the average claims cost for Commonwealth Group retirees of cities, counties, municipalities and regional universities for whom active employees do not participate in the Commonwealth's Public Employee Health Insurance Program, were 56% higher than that of other Commonwealth Group members. In aggregate, the 5,790 CERS and regional university retiree participants and their 3,072 covered dependents in the Commonwealth Group added $9.9 million in excess cost that was absorbed by the Commonwealth and other Commonwealth Group members in calendar year 2000.

As the Commonwealth's Public Employee Health Insurance Program offers a choice of healthcare options through up to three carriers per county, the overall cost of the program includes the selection cost resulting from choice and the splintering of risk between carriers. To eliminate or mitigate this risk, the Commonwealth could:

- reduce its healthcare options to one, or
- self-fund its entire program or consolidate its insured program under one health insurer.

Either of these alternatives would be a drastic change for Commonwealth Group members.

Another alternative, one contemplated under the Health Purchasing Alliance, is to risk adjust the premiums paid to the Commonwealth Group's insurance carriers based on the age, gender or health status of the individuals who enroll in a particular healthcare option. This type of risk adjustment is controversial, since it results in premium adjustments after individuals have selected the health plan in which they wish to enroll. Additionally, some insurers could legitimately argue that the segment of the Commonwealth Group enrolled in the plans they insure has a better health status profile due to their efforts with respect to preventive care or the management of care for individuals with chronic health conditions. Based on the age and gender of Commonwealth Group members enrolled in each insurer's plans as of February 2001, the expected cost differential between the insurer covering the group with the lowest expected healthcare cost and the insurers covering the groups with age and gender characteristics that would be expected to generate the highest healthcare cost is only 5.3%.

Legislative Proposals

In the past, bills have been introduced that would allow individuals who are not Commonwealth employees or retirees or employees of groups that participate in a Commonwealth sponsored retirement program to join the Commonwealth Group. The claims experience of COBRA beneficiaries covered under the Commonwealth's Public Health Insurance Program's in 2000 strongly illustrates that when individuals are allowed to "buy into" a group health insurance program, their claims cost will be substantially higher than the average of the group itself. In 2000, the average claims cost of COBRA members was over 2 ½ times that of the remainder of the Commonwealth Group. This type of impact is also likely if groups were allowed to enter and exit the Commonwealth Group at will.

As mentioned previously, the amount providers charge for various healthcare services varies between different geographic areas within the Commonwealth. Bills have been introduced in the past that would allow the Commonwealth's insurance carriers to charge different rates in different areas of the state. If this provision were enacted, especially in conjunction with a provision that would preclude the Commonwealth from restricting the number of insurance carriers offered in a given geographic area, the carriers would have no incentive to blend the costs from high and low cost areas. Although the Commonwealth funds the lowest cost single Option A in a given county, Commonwealth Group members pay the entire premium attributable to their dependents' coverage. Therefore, if the current geographic rate blending employed by the Commonwealth and supported by KRS 18A.225(2)(c) were eliminated, Commonwealth Group members' premium contributions for dependent coverage would increase in areas with higher healthcare costs.

Self-Funding

The majority of other states (72%) self-fund at least one of their health insurance options. However, only 15% self-fund their entire healthcare program.

The Commonwealth's insured funding arrangement is consistent with other states in view of the plan types it offers to employees and the heavier concentration of Commonwealth Group members enrolled in HMOs.

- Seventy-six percent of other states responding to the Commonwealth's survey insure all of their HMO offerings. Another 12% insure some of their HMO offerings and self-fund other HMO options. Only 12% self-fund all of their HMO offerings.
- For POS and PPO options, other states are split roughly in half regarding their funding arrangement – insured vs. self-funded.

The advantages and disadvantages of self-funding are:

Advantages

- When claims are less than projected, the self-funded plan (or the employer) benefits rather than an insurance carrier.
- In the early months of a self-insured arrangement, claims incurred prior to the effective date of self-funding are paid from the prior insured plan's reserves. This results in an immediate cash flow advantage to the self-insured plan, which should be the source for establishing a reserve for claims incurred but not yet paid.

- Expected costs under a self-funded arrangement are typically 2-5% less than what they would be if the plan were insured due to:
  - the elimination of insurer risk charges,
  - the interest earned on reserves, and
  - higher prescription drug formulary rebates.
- A self-funded program may have more negotiation flexibility with providers. Through direct contracting, a self-funded program may be able to include more providers in the plan's network, albeit at a higher cost to the plan.
- A self-funded program typically has more design flexibility. For example, a self-funded employer can offer options with HMO style benefits in areas where HMOs do not exist. This could result in more consistency in the benefit options offered to plan participants in different geographic areas of the Commonwealth.
- Currently, the Commonwealth's health insurance risk pool is split among five insurance carriers, segmenting its risks based on plan availability by geographic area and individual employees/retirees' selections. Under a self-funded arrangement, the Commonwealth could consolidate its risk pool and have increased flexibility in allocating its healthcare program's costs.
- By self-funding, employers increase their ability to carve out segments of their healthcare program, like pharmacy benefit management or behavioral health services, to customize the program to meet its specific requirements. Through these carve out arrangements, greater consistency in plan administration, including items like prescription drug formulary changes, may be achieved.

Disadvantages

- The financial risk an employer assumes is the biggest drawback to self-funding. In a self-funded arrangement, if claims and expenses exceed projections, it is the employer that must absorb the deficit. Given the magnitude of the Commonwealth's healthcare program's total expenditures, if claims and expenses exceeded projections by only 5%, a deficit of over $30 million would result. This level of variance or more is possible, particularly in the first year of self-funding due to the number of changes that are likely to occur in:
  - Provider network composition and therefore charges and practice patterns;
  - Provider reimbursement arrangements, if networks change; and
  - Claims and care management, if vendors managing the program change.

  Additionally, in periods of increasing healthcare trends, as is the case currently, there is a greater probability that actual costs will deviate from projected costs.
- It is essential to establish and maintain adequate claim reserves to properly fund a self-insured plan's obligations. Any pressure to use healthcare program reserves for other purposes must be resisted if the program is to be financially sound. If reserves reach excessive levels, careful management is required to maintain stability in employee contribution amounts, particularly given that the Commonwealth does not currently explicitly subsidize the cost of dependent healthcare coverage.
- Under a self-funded arrangement, the Commonwealth may not be able to duplicate the current provider networks in place. If this occurs, the relationship between a patient and his/her healthcare provider(s) may be disrupted.

- While self-funding may increase the Commonwealth's flexibility in negotiating with healthcare providers and the options offered to its members, this flexibility could result in increased health plan costs for the Commonwealth and its employees/retirees.
- Insured plans resolve contested or unusual claims and act as a third-party buffer for the employer. Unless the Commonwealth delegates fiduciary responsibility for claim determinations and payments to the third party administrator, under a self-funded arrangement, the Commonwealth would be faced with making these determinations. Claim denials may be directly attributed to the Commonwealth and have the potential for causing increased employee dissatisfaction or increased pressure to pay ineligible expenses thereby increasing plan expenditures. Additionally, legal actions taken by plan members could include the Commonwealth.
- When self-funded, a health plan becomes subject to Internal Revenue Code Section 105(h) non-discrimination rules. Given the current structure of the Commonwealth's Public Employee Health Insurance Program, this should not create a problem. However, this provision would need to be considered if any revisions to the plan were considered that would discriminate in favor of highly compensated employees as defined by Section 105(h). It also would need to be taken into account if the Commonwealth becomes involved in decisions as to whether to cover questionable expenses under the plan for highly compensated individuals or their family members.
- The Commonwealth's current program structure supports regional health plans for which the Commonwealth Group comprises 70% or more of some plans' enrollment. In aggregate, the Commonwealth Group comprises about 20% of the health insurance market in Kentucky.[20] As some of the Commonwealth's insurance carriers are not postured to operate in a self-funded environment, if the Commonwealth were to self-fund the Commonwealth's Public Employee Health Insurance Program, it could adversely impact the health insurance market for all Kentucky health insurance consumers.
- Under a self-funded arrangement, the Commonwealth would need to assume responsibility for new functional requirements that are not present today:
  - establishing and maintaining a "fund" to hold reserves;
  - setting up banking procedures for remittance of administrative expenses and claim payments to the third party administrator(s) the Commonwealth selects to pay its healthcare claims; and
  - implementing centralized facilit(ies) to determine the "premiums" due each month from each entity participating in the Commonwealth's Public Employee Health Insurance Program, collecting "premiums" from each entity, reconciling premiums received with each entity's eligibility information, remitting monthly payments for administrative expenses and weekly or daily payments for claims to the Commonwealth's third party administrator(s), and reconciling the balance in the reserve fund.

  New procedures and systems would need to be established and ***additional staffing*** obtained to support these additional functional requirements.

[20] *Department of Insurance*

Healthcare Third Party Administrator and Vendor Evaluation

A summary of the four primary methods employer health plan sponsors use to evaluate healthcare vendors and their strengths and weaknesses is provided in the following chart:

	Pros and Cons of Primary Healthcare TPA and Vendor Evaluation Methods	
	Strengths	**Weaknesses**
Written Proposals	• Written offer • Allows for collection of a great amount of quantitative data	• Limited in ability to capture qualitative information • Possibility for misinterpretation • No validation of vendor representations
Oral Presentations	• Allows for better collection of qualitative information than written proposals • Provides ability to clarify vendors' capabilities	• Depend heavily on vendor representations • No written offer if not coupled with written proposal • Limited in ability to collect quantitative data unless coupled with written proposal
On-Site Reviews	• Allows for verification of vendor representations • Allows for in-depth assessment of vendor's staff and systems	• Time and expertise required to conduct on-sites
Audits	• Allows for verification of vendor representations	• Time and expertise required to conduct audits

To-date, the Commonwealth has used written proposals to evaluate health insurance vendors for the Commonwealth's Public Employee Health Insurance program. Additionally, insurance carriers' reported results in relation to contractual performance guarantees and periodic meetings are used by OPEHI to manage the Commonwealth's Public Employee Health Insurance vendors.

State Survey Data Sources

States for whom no data is available are shaded in red

The primary data source used for all other states is shaded in yellow

	Commonwealth Survey	Mercer Survey	Internet
Alabama	X	X	X
Alaska		X	X
Arizona	X	X	X
Arkansas	X		X
California	X	X	X
Colorado	X	X	
Connecticut	X		
Delaware	X		X
Florida	X	X	X
Georgia	X	X	
Hawaii			
Idaho			X
Illinois	X		
Indiana	X	X	X
Iowa	X	X	X
Kansas	X	X	X
Louisiana	X		X
Maine	X	X	X
Maryland			
Massachusetts			X
Michigan	X	X	X
Minnesota		X	X
Mississippi	X	X	
Missouri	X	X	X
Montana		X	X
Nebraska	X		X
Nevada			X
New Hampshire	X		
New Jersey	X	X	X
New Mexico	X		
New York	X	X	X
North Carolina	X		X
North Dakota	X	X	
Ohio	X	X	X
Oklahoma	X	X	X
Oregon			X
Pennsylvania	X	X	X
Rhode Island			
South Carolina	X	X	X
South Dakota	X		X
Tennessee	X	X	
Texas	X	X	X
Utah	X	X	X
Vermont	X	X	
Virginia	X	X	X
Washington		X	X
West Virginia	X	X	X
Wisconsin	X	X	X
Wyoming	X	X	
Primary Data Source:	38	4	4

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
Access To Justice Fndtion	4	0
Adair Co Ambulance Ser	17	1
Adair Co Conservation Dis	2	0
Adair Co Water District	10	1
Adair County Attorney	3	0
Adair County Fiscal Court	49	5
Adanta/Behavioral Hlth Sr	439	12
Allen Co Ambulance Svc	15	0
Allen Co Conservation Dis	1	0
Allen Co Sheriffs Office	8	0
Allen County Attorney	5	0
Allen County Fiscal Court	66	3
Alton Water & Sewer Dist	3	0
Anchorage Fire Protection	33	0
Anderson Co Conserv Dist	1	0
Anderson Co. Fiscal Court	68	6
Anderson County Attorney	5	0
Anderson Public Library	6	0
Anderson-Dean Comm Park	4	0
Appalachian Res & Defense	51	0
Ashland Police & Fire	110	50
Asst Of Commonwealth Atty	14	0
Audubon Area Comm Ser Inc	398	1
Ballard County Attorney	2	0
Ballard County Fiscal Ct	59	2
Ballard/Carlisle/Liv Pb L	1	0
Barbourville Utility Comm	50	4
Bardstown-Nelson Co Touri	4	0
Bardwell City Utilities	4	3
Barkley Lake Water Dist	16	0
Barren Co Corr Ctr	22	1
Barren Co Fiscal Ct	50	4
Barren Co Soil Cons Dis	1	0
Barren County Attorney	16	0
Barren County Sheriffs	7	0
Barren River Area Dev	33	0
Barren/Metcalfe Co Amb Sr	4	0
Barren/Metcalfe Co Amb Sv	31	0
Bath Co Fiscal Court	39	4
Bath Co Water District	10	0
Bath County Attorney	3	0
Bd Of Emergency Med Svcs	15	0
Beech Fork Water Comm	6	0
Bell Co Conservation Dist	1	0
Bell Co Court Clerk	10	0
Bell Co Emergency Serv	16	0
Bell Co Fiscal Ct	110	7
Bell Co Public Library	4	1
Bell Co Solid Waste Offic	5	0
Bell County Attorney	11	0
Bell/Whitley Comm Action	84	3
Belle Of Louisville	23	0
Benton Electric System	10	3
Berea Sewer Commission	10	0
Big Sandy Area Comm Pro	96	3
Big Sandy Area Dev Dist	49	0
Big Sandy Area Juv Det Ct	13	0
Big Sandy Water District	8	0
Black Mudd Fire Prot Dist	13	1
Blue Grass Comm Action	127	3
Bluegrass Area Dev Disric	30	0
Bluegrass Reg Mhmr Board	1114	59
Bluegrass St Skills Corp	1	0
Boone Co Fiscal Court	274	16
Boone Co Library Dist	32	1
Boone Co Master Comm	2	0
Boone Co Planning Comm	18	0
Boone Co Police	63	11
Boone Co Water District	24	3
Carrollton Utilities Comm	21	2
Carrollton/Carr Co Rec Tr	1	0
Carrollton/Carroll Co Par	0	0

Agency Name	# of Actives	# of Retirees
Boone County Attorney	8	0
Bourbon Co Fire Dept	10	1
Bourbon Co Fiscal Court	72	4
Bourbon Co Health Center	12	1
Bourbon Co Sheriff'S Dept	7	1
Bowl Grn Conv & Visit Bur	4	1
Bowl Grn Warren Airprt Bd	4	0
Bowling Gr/Warren Comm Ed	10	0
Bowling Grn Hum Right Com	2	0
Bowling Grn Municipal Uti	224	52
Bowling Grn Public Lib	30	2
Boyd Co Ambulance Service	20	5
Boyd Co Conservation Dist	1	0
Boyd Co Des Office	2	0
Boyd Co Public Library	25	3
Boyd County Attorney	7	0
Boyd County Fiscal Court	121	9
Boyle Co Sheriff Dept	7	0
Boyle County Fiscal Court	117	3
Bracken Co Fiscal Court	38	0
Bracken County Pub Librar	4	0
Breathitt Co Fiscal Court	61	2
Breathitt Co Public Lib	4	1
Breathitt Co Soil Conserv	1	0
Breckinridge Co Attorney	3	0
Breckinridge Co Clerk Off	9	1
Breckinridge Co Fiscal Ct	109	1
Breckinridge Co Health Bd	14	1
Buechel Fire Protect Dist	30	0
Buffalo Trace Ar Dev Dist	22	0
Buffalo Trace Gateway Ntf	8	0
Bullitt Co Conservat Dist	1	1
Bullitt Co Fiscal Court	84	7
Bullitt Co Sheriff&Jailer	46	3
Bullitt County Attorney	14	0
Bullitt County Clerk	22	4
Bullock Pen Water Dist	13	1
Burkesville Police & Fire	6	0
Butler County Attorney	3	0
Butler County Fiscal Ct	63	5
C E M P Area Policy Counc	71	0
Caldwell Co Fiscal Court	61	5
Caldwell County Ems	10	2
Calloway Co Fiscal Court	203	7
Calloway Co Public Librar	7	0
Calloway County Attorney	5	0
Camp Taylor Fire Pro Dist	6	0
Campbell Co Courthouse	1	0
Campbell Co Fire Dept Ii	14	0
Campbell Co Fire Dist #5	9	0
Campbell Co Fiscal Ct	135	9
Campbell Co Master Comm	1	0
Campbell Co Patrolman	28	5
Campbell Co Public Librar	28	2
Campbell Co Sheriff	11	4
Campbell County Clerk	29	2
Campbellsvle Mun Wtr&Sewr	39	6
Cannonsburg Vol Fire Dept	3	0
Cannonsburg Water Dist	10	2
Capital Community E I D A	2	0
Capital Plaza Authority	3	0
Career Ladder Commission	3	0
Carlisle Co Fiscal Court	32	3
Carlisle Co Sanit Dist 1	1	0
Carlisle County Attorney	1	0
Carroll Co Fiscal Ct	81	3
Carroll Co Public Library	8	1
Carroll Co Water District	8	0
Carroll County Attorney	4	0
City Of Clarkson	2	0
City Of Clay	7	1
City Of Clay Police	1	0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
Carter Co Emer Ambul Dist	30	1
Carter Co Fiscal Ct	69	7
Carter County Attorney	1	0
Casey Co Ambulance Serv	11	2
Casey Co Fiscal Court	48	2
Casey County Attorney	5	0
Catlettsburg Police/Fire	16	2
Central Canteen Corp	0	0
Central City Mun Wtr&Sewr	21	0
Central City Public Schoo	30	0
Central Ky Comm Action	219	3
Central Ky Ed Cooperative	4	0
Central Ky Educ Coop.	4	
Central Ky Legal Services	15	0
Central Ky Special Educ.	3	
Christian Co Cons Dist	2	0
Christian Co Fiscal Court	146	15
Christian Co Water Dist	8	0
Christian County Attorney	2	0
Circuit Clerks	2140	99
City Clarkson	2	0
City County Planning Comm	1	0
City Of Adairville	9	0
City Of Alexandria	8	0
City Of Alexandria Police	13	1
City Of Anchorage	15	1
City Of Anchorage Police	10	2
City Of Ashland	213	25
City Of Auburn	8	0
City Of Auburn Police	3	0
City Of Barbourville	15	0
City Of Barbourville Pd	14	0
City Of Bardstown	80	8
City Of Bardstown P&F	22	8
City Of Bardwell	9	1
City Of Beattyville	24	1
City Of Beaver Dam	19	0
City Of Bedford	3	0
City Of Bellefonte	3	0
City Of Bellevue	18	4
City Of Bellevue P & F	18	4
City Of Benham	11	1
City Of Benton	39	4
City Of Benton Cty Police	7	2
City Of Berea	68	4
City Of Bloomfield	7	0
City Of Bowling Green	387	86
City Of Brandenburg	13	3
City Of Burkesville	25	0
City Of Burnside	4	0
City Of Burnside Pol Dept	4	0
City Of Butler	0	0
City Of Butler Police	1	0
City Of Cadiz	28	0
City Of Calhoun	11	0
City Of Calvert City	25	0
City Of Campbellsburg	2	0
City Of Campbellsville	71	5
City Of Campbellsvle P&F	32	4
City Of Campton	8	0
City Of Caneyville	5	0
City Of Carlisle	23	0
City Of Carrollton	23	0
City Of Catlettsburg	10	0
City Of Cave City	10	0
City Of Central City	42	1
City Of Hazard	81	0
City Of Henderson	172	23
City Of Highland Heights	25	3
City Of Hillview	3	0
City Of Hillview Police	13	0
City Of Hindman	4	0

Agency Name	# of Actives	# of Retirees
City Of Cold Spring	11	0
City Of Cold Spring Pol	10	2
City Of Columbia	44	2
City Of Corbin	85	11
City Of Covington	130	10
City Of Crab Orchard	1	0
City Of Crab Orchard Poli	1	0
City Of Crescent Springs	15	2
City Of Crestview Hills	3	0
City Of Crittenden	3	0
City Of Crittenden Police	0	0
City Of Crofton	9	0
City Of Cynthiana	69	7
City Of Cynthiana P&F	45	19
City Of Danville	68	5
City Of Dawson Springs	29	3
City Of Dayton	16	1
City Of Dayton Pol & Fire	20	6
City Of Dixon	2	0
City Of Douglass Hills	2	0
City Of Dry Ridge	15	0
City Of Dry Ridge Police	5	0
City Of Earlington	4	0
City Of Earlington Police	3	0
City Of Eddyville	15	0
City Of Edgewood	43	2
City Of Edmonton	16	1
City Of Edmonton Police	6	0
City Of Elizabethtown	158	10
City Of Elizabethtown P&F	87	17
City Of Elkton	16	0
City Of Elsmere	7	1
City Of Elsmere Police	11	1
City Of Eminence	13	0
City Of Erlanger	41	7
City Of Erlanger Pol&Fire	45	8
City Of Falmouth	8	0
City Of Falmouth Police	6	0
City Of Ferguson	1	0
City Of Ferguson Pol Dept	1	0
City Of Flatwoods	27	0
City Of Flemingsburg	18	0
City Of Flemingsburg Pol	5	0
City Of Florence	47	2
City Of Fort Mitchell	9	0
City Of Fort Thomas	28	7
City Of Fort Wright	24	3
City Of Frankfort	152	13
City Of Frankfort Sewer D	25	0
City Of Franklin	45	1
City Of Franklin Fire Dep	4	0
City Of Franklin Police	18	0
City Of Fredonia	2	0
City Of Frenchburg	5	0
City Of Ft Mitchell P&F	27	2
City Of Georgetown	107	1
City Of Georgetown P&F	86	8
City Of Glasgow	86	16
City Of Glasgow Pol & Fir	72	8
City Of Greensburg	33	0
City Of Guthrie	9	0
City Of Hardinsburg	16	0
City Of Harrodsburg	56	7
City Of Harrodsburg P & F	34	10
City Of Hartford	18	0
City Of Hawesville	15	0
City Of Muldraugh	9	0
City Of Munfordville	11	0
City Of Murray	115	13
City Of New Castle	4	0
City Of New Castle Police	2	1
City Of New Haven	4	0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
City Of Hodgenville	21	1
City Of Hopkinsville	116	7
City Of Hopkinsville P&F	146	56
City Of Horse Cave	11	0
City Of Hurstbourne	2	0
City Of Hyden	4	0
City Of Independence Pol	32	1
City Of Irvine	18	1
City Of Irvington	10	1
City Of Island	4	0
City Of Jackson	32	0
City Of Jamestown	32	4
City Of Jeffersontown	107	18
City Of Junction City	12	0
City Of Lagrange	11	0
City Of Lagrange Police	12	3
City Of Lakeside Park	1	0
City Of Lancaster	27	1
City Of Lancaster Police	9	0
City Of Lawrenceburg	57	5
City Of Lebanon	47	4
City Of Lebanon Jct Polic	5	0
City Of Lebanon Junction	6	0
City Of Leitchfield	38	2
City Of Leitchfield P&F	18	1
City Of Lewisport	14	1
City Of Liberty	17	3
City Of Livermore	11	1
City Of London	42	1
City Of London Pol Dept	33	7
City Of Loretto	1	0
City Of Louisa	16	0
City Of Louisville	2522	304
City Of Louisville Fire	606	324
City Of Louisville Police	754	420
City Of Ludlow	9	2
City Of Lyndon	4	0
City Of Madisonville	197	8
City Of Madisonville P&F	100	9
City Of Manchester	30	1
City Of Manchester Police	12	0
City Of Marion	24	4
City Of Mayfield	91	6
City Of Maysville	106	13
City Of Meadow Vale	2	0
City Of Meadow Vale Polic	3	2
City Of Melbourne	1	0
City Of Middlesboro	34	2
City Of Midway	8	0
City Of Millersburg	3	0
City Of Millersburg Polic	2	0
City Of Milton	6	0
City Of Monticello	18	1
City Of Morehead	58	8
City Of Morganfield	44	4
City Of Morganfield P&F	13	3
City Of Morgantown	28	4
City Of Morgantown Police	6	0
City Of Mount Olivet	1	1
City Of Mount Vernon	21	0
City Of Mt Ster Pol Dept	18	0
City Of Mt Sterling	28	0
City Of Mt Washington	32	0
City Of Tompkinsville	16	0
City Of Tompkinsville Pol	8	0
City Of Union	1	0
City Of Versailles	52	8
City Of Versailles Police	32	6
City Of Villa Hills	7	0
City Of Villa Hills Pol	10	0
City Of Vine Grove	9	0
City Of Vine Grove P Dept	5	0

Agency Name	# of Actives	# of Retirees
City Of New Haven Police	2	0
City Of Newport	80	6
City Of Nicholasville	97	12
City Of Nicholasville P&F	80	7
City Of Oak Grove	11	0
City Of Olive Hill	30	0
City Of Owensboro	237	46
City Of Owingsville	8	1
City Of Paducah	200	47
City Of Paintsville	52	0
City Of Paris	65	5
City Of Paris Pol & Fire	53	18
City Of Park City	1	0
City Of Park City Police	2	0
City Of Park Hills	4	0
City Of Parkhills Pol Dep	6	0
City Of Perryville	3	0
City Of Pikeville	31	0
City Of Pikeville P&F	38	5
City Of Pineville	21	3
City Of Pleasureville	1	0
City Of Pleasureville Pol	1	0
City Of Prestonsburg	86	3
City Of Princeton	29	0
City Of Prospect	5	0
City Of Prospect Police	8	1
City Of Providence	87	14
City Of Radcliff	132	10
City Of Richmond	124	12
City Of Rolling Hills	0	0
City Of Rolling Hills Pol	2	0
City Of Russell	32	0
City Of Russell Spgs Pol	6	1
City Of Russell Springs	16	0
City Of Russellville	78	4
City Of Russellville P&F	27	9
City Of Sacramento	5	0
City Of Salyersville	30	0
City Of Scottsville	51	9
City Of Sebree	8	0
City Of Shelbyville	31	2
City Of Shelbyville P&F	37	11
City Of Shepherdsville	20	1
City Of Shepherdsvle Pol	23	0
City Of Shively	13	0
City Of Shively P & F	44	20
City Of Silver Grove	6	0
City Of Silver Grove Pol	1	0
City Of Somerset	120	11
City Of Southgate	15	1
City Of Southgate Police	8	0
City Of Springfield	16	1
City Of Springfield Polic	7	1
City Of St Matthews	58	14
City Of Stamping Ground	6	0
City Of Stanford	15	0
City Of Stanton	12	2
City Of Sturgis	14	4
City Of Sturgis P&F	8	1
City Of Taylor Mill	14	0
City Of Taylor Mill P&F	21	1
City Of Taylorsville	12	0
City Of Taylorsville Pol	5	0
Danville Police & Fire	50	21
Daviess Co Airport Bd	4	1
Daviess Co Clerk	28	4
Daviess Co Detention Ctr	56	4
Daviess Co Fire Dept	17	3
Daviess Co Fiscal Court	100	12
Daviess Co Library Dist	31	0
Daviess Co Sheriff	12	1
Daviess County Attorney	2	0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
City Of W Buechel Police	10	0
City Of Walton	9	0
City Of Walton Police Dep	2	0
City Of Warsaw	17	0
City Of Warsaw Police Dep	4	0
City Of Wayland	1	0
City Of West Buechel	6	0
City Of West Liberty	30	0
City Of West Point	7	0
City Of Whitesburg	17	1
City Of Whitesville	4	0
City Of Wickliffe	7	0
City Of Wilder	24	2
City Of Williamsburg	70	0
City Of Williamsburg Cda	4	0
City Of Williamstown	31	5
City Of Williamstown Pol	6	0
City Of Wilmore	18	0
City Of Wilmore Police De	7	1
City Of Winchester	44	1
City Of Wurtland	6	0
Clark Co Consvation Dist	1	0
Clark Co Library Bd	13	4
Clark Co Sheriffs Dept	25	1
Clark County Attorney	6	0
Clark County Fire Dept	26	2
Clark County Fiscal Court	143	6
Clay Co Master Commission	0	0
Clay County 911 Board	6	0
Clay County Attorney	4	0
Clay County Treasurer	105	5
Clinton Co Attorney	3	0
Clinton Co Fiscal Court	63	1
Clinton Co Public Library	2	1
Clinton County Attorney		0
Comm Action Southern Ky	201	1
Comm Backside Improve	5	0
Comm Of Sinking Fund		9
Commonwealth Credit Union	180	2
Communicare Inc	278	8
Comprehend Inc Reg Mhmr B	108	5
Covington Police & Fire	230	88
Crime Victims Compensatio	19	1
Crittenden Co Attorney	3	0
Crittenden Co Fis Ct	51	0
Crittenden/Liv Co Wat Dis	11	0
Cumberland Co Attorney	2	0
Cumberland Co Fiscal Ct	25	3
Cumberland Co Public Lib	8	0
Cumberland Co Soil & Wat	3	0
Cumberland Co Treasurer	2	0
Cumberland River Mhmr Bd	311	15
Cumberland Tr Legal Servi	39	0
Cumberland Val Area Dev	30	2
Cynthiana Harrison Co Jpc	2	0
Cynthiana Harrison Co R D	1	0
Cynthiana/Harrison Librar	4	1
Daniel Boone Dev Council	61	2
Danville Boyle Co Rec	6	0
Danville Boyle Planning	3	0
Frankfort Police & Fire	138	40
Franklin Co Cons Dist		0
Franklin Co Council Aging	34	0
Franklin Co Detention Cen	0	0
Franklin Co Fire Dept	39	8
Franklin Co Fiscal Court	67	9
Franklin County Attorney	11	0
Franklin County Sheriff	61	2
Franklin Electric Plnt Bd	4	0
Franklin/Simpson Parks Bd	8	1
Ft Thomas Police & Fire	32	22
Fulton Co Library	3	0

Agency Name	# of Actives	# of Retirees
Daviess County D E S	1	0
Daviess County Sheriff	33	1
Dept For Adult Educ & Lit	28	1
Dept For Technical Educ	32	4
Dept For Vocational Rehab	277	10
Dixie Police Authority	2	0
E Casey Co Water District	7	0
E Ky Concen Employ Pro	38	15
E Pennyrile Dist Hlth Dep	63	0
East Clark Co Water Dist	6	0
East Ky Utilities Inc	7	1
East Pendleton Water Dist	6	0
Eastern Canteen Inc	7	0
Eastern Kentucky Universi	943	50
Eastern Ky Expo Center	1	0
Eastern Ky Univ	205	93
Eastwood Fire Prot Dist	8	0
Edgewood Fire Protection	6	0
Edmonson Co Ambulance Dis	5	0
Edmonson Co Ambulance Ser	11	0
Edmonson Co Conserv Dist	1	0
Edmonson Co Dental Clinic	1	0
Edmonson Co Fiscal Crt	36	1
Elec Plt Bd Of Vanceburg	18	5
Elizabethtown Tour/Con Bu	3	0
Elliott Co Amb Service	11	0
Elliott Co Fiscal Ct	69	6
Elliott County Sheriff	4	1
Elsmere Fire Protection	9	0
Estill Co Conservation Di	1	0
Estill Co Fiscal Court	102	2
Estill Co Water Dist No 1	6	0
Estill County Ems	16	0
F&A Appropriations Unclas	2	0
F&A Ky Veterans Center	1	4
Family Health Center	263	16
Farmdale Water District	5	0
Fayette Co Clerk	77	6
Fayette Co Sheriff	82	10
Fayette County Attorney	6	1
Fern Creek Fire Prot Dist	44	0
Fivco Area Developmt Dist	20	2
Fkt/Fkln Co Tour&Conv Com	5	0
Fleming Co Fiscal Court	52	5
Fleming County Attorney	11	2
Fleming County Library	4	0
Fleming County Sheriffs	8	0
Flemingsbrg-Fleming Co Ds	3	0
Flemingsburg-Fleming Cedc	2	0
Flood Control Adv Comm	2	0
Florence Police & Fire	91	16
Florence Water&Sewer Com	34	4
Floyd Co Fiscal Court	169	4
Floyd Co Health Center	53	3
Floyd Co Library	8	0
Floyd County Attorney	12	0
Floyd County Consv Dist	2	0
Fn&A Empower Ky	4	0
Fn&A Sheriff Exp Allow	2	0
Frankfort Elec Water Bd	192	35
Hardin Co Water Dist #2	43	3
Hardin County Attorney	17	0
Hardin County Clerk Offic	32	1
Hardin County Sheriff	1	0
Harlan Co Conserv Dist	1	0
Harlan Co Fis Ct	105	8
Harlan County Attorney	6	0
Harlan County C A A	44	0
Harrison Co Conserva Dist	1	0
Harrison Co Fiscal Court	52	3
Harrods Creek Fire Dist	25	0
Hart Co Ambulance Service		0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
Fulton County Fis Ct	60	0
Gallatin Co Fiscal Court	57	1
Gallatin Co Public Lib	4	0
Gallatin Co Water Dis	6	0
Gar,Qui,Ky-O-Hts Wtr Dist	3	0
Garrard Co Fiscal Court	62	6
Garrard Co Public Library	4	0
Garrard County Attorney	3	0
Gateway Area Dev District	12	0
Gateway Comm Ser Organiz	80	2
George Coon Public Librar	9	0
Georgetown Water & Sewer	48	4
Georgetown-Scott Co P Com	4	0
Georgetown/Scott Co Parks	14	0
Georgetown/Scott Tourism	2	0
Glasgow Cemetery Comm	2	0
Glasgow Electric Plant Bd	52	5
Glasgow Water Company	48	4
Governor'S Scholar Progra	1	0
Grant Co Fiscal Court	19	1
Grant Co Planning Comm	3	0
Grant Co Publ Safety Comm	9	0
Grant Co Public Library	5	1
Grant Co Solid Waste Mgmt	0	0
Grant County Child Suppor	8	0
Grant County Fiscal Court	107	4
Graves Co Library	5	0
Graves County Attorney	11	0
Graves County Fiscal Ct	87	3
Grayson Co Conserv Dist	1	0
Grayson Co Fiscal Court	57	2
Grayson Co Library	6	0
Grayson Co Sheriff & Jail	54	1
Grayson County Attorney	8	1
Greater Lex Conv&Visitor	19	1
Green Co Ambulance Serv	8	1
Green Co Ambulance Svc	2	0
Green County Fiscal Court	30	2
Green Riv Area Del Dist	44	1
Green River Reg Educ Coop	6	0
Green River Regional Educ	2	
Green Rvr Reg Mhmr Bd	100	21
Green/Taylor Water Dist	9	0
Greenup Co Atty/Child Sup	6	0
Greenup Co Envir Comm	5	0
Greenup Co Fiscal Ct	96	6
Gtr Hardin Co Narc Task F	2	0
H-Ville/Chris Co Rec Dept	10	0
Hancock Co Fiscal Court	56	1
Hancock Co Public Library	6	0
Hancock County Attorney	2	0
Hardeman Water District	1	0
Hardin Co Fiscal Court	228	9
Hardin Co Library	10	1
Hardin Co Sheriff Dept	54	0
Hardin Co Soil Con Dist	1	0
Hardin Co Water Dist #1	26	0
Independence Fire Dist	22	0
Interstate Mining Compact	4	0
Irvine Municipal Utility	15	4
Jackson Co Conserv Dist	1	0
Jackson Co Fiscal Court	111	0
Jackson Co Master Comiss	4	1
Jackson County Attorney	4	0
Jeff Circuit Court Comm	16	3
Jeff Co Fire Pro Dist 14	28	0
Jeff Co Med Center Laundr	57	4
Jeff Co Med Ctr Stm & Chl	15	4
Jeff Co Metro Sewer Dist	617	230
Jeff Co Soil/Conser Dist	2	0
Jefferson Co Attorney	234	9
Jefferson Co Clerk	261	13

Agency Name	# of Actives	# of Retirees
Hart Co Conservation Dist	1	0
Hart Co Solid Waste Svc	13	0
Hart County Attorney	7	0
Hart County Fiscal Court	68	3
Harvey Helm Mem Library	5	1
Hazard Police & Fire	34	0
Hb 813(1998) Krs 61.702(5		1
Hebron Fire Protection	21	0
Henderson Co Attorney	10	0
Henderson Co Fiscal Court	144	4
Henderson Co River Auth	12	1
Henderson Co Tourist Comm	2	0
Henderson Co Water Dist	10	0
Henderson Mun Power&Light	57	8
Henderson Mun W & S Dept	76	7
Henderson Police & Fire	112	38
Henderson Public Library	16	1
Hendron Water District	7	0
Henry Co Fiscal Court	48	3
Henry Co Library	4	0
Henry Co Water Dist #2	16	0
Henry County Attorney	2	0
Hickman Co Fiscal Court	41	2
Hickman County Attorney	1	0
Hickman Electric System	7	0
Hickman/Fulton Riv Prt Au	11	0
Highschool Athletic Assoc	5	1
Highview Fire District	10	0
Hopk Christian Co Eoc	18	2
Hopkins Co Fisc Ct-Jail	57	1
Hopkins Co Fiscal Court	111	4
Hopkinsvl Electric System	37	14
Hopkinsvl Water Env Ath	68	15
Hopkinsvle Christ Library	7	0
Hous Auth Of Flemingsburg	2	0
Hous Auth Of Henderson	33	5
Hous Auth Of Hickman	7	0
Hous Auth Of Owingsville	4	0
Hous Auth Of Springfield	5	1
Housing Auth Bowling Grn	43	2
Housing Auth Dawson Spg	8	2
Housing Auth Of Cadiz	3	0
Housing Auth Of Covington	28	3
Housing Auth Of Frankfort	10	1
Housing Auth Of Greensbur	5	0
Housing Auth Of Hopkinsvl	32	1
Housing Auth Of Maysville	10	2
Housing Auth Of Morehead	8	1
Housing Auth Of Owensboro	15	0
Housing Auth Of Paintsvle	14	1
Housing Auth Of Shelbyvle	4	1
Housing Auth Of Somerset	13	1
Housing Auth Of Vanceburg	1	0
Housing Auth/ Lawrence Co	2	0
Housing Authority Of Cynt	13	0
Housing Authority Scotts	3	0
I H R F Police Dept	11	0
Ky Magistrates/Comm Assoc	2	0
Ky River Area Dev Dist	24	2
Ky River Comm Care Inc	541	6
Ky River Foothills Dev Co	87	0
Ky School Boards Associat	30	1
Ky Western Waterland	1	0
Kyiana Reg Planning Dev	63	2
Lagrange Utility Comm	13	1
Lake Cumberland C S O	206	8
Lake Cumberland Dev Dist	46	5
Lakeside/Crestviewhls Pol	12	2
Larue Co Fiscal Court	59	2
Larue Co Public Library	4	0
Larue Co Water Dist #1	6	0
Larue County Attorney	6	0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
Jefferson Co Corrections	432	30
Jefferson Co Fiscal Court	1615	123
Jefferson Co Sheriff	253	40
Jefferson County Attorney	69	0
Jefferson County Police	454	245
Jeffersontown Fire Dist	36	1
Jessamine Co Fiscal Court	157	5
Jessamine Co Sheriffs Dpt	19	0
Johnson Co Fiscal Court	40	0
Johnson Co Library	4	1
Johnson County Attorney	14	0
Judicial Max Krs61.680(3)	0	0
Juvenile Justice	1	0
Kaca Unemployment Ins Fun		0
Kaco Unemployment Ins Fun	1	0
Kctcs Correctional Facili	0	
Kea President	2	
Kenton Co Airport Bd	86	31
Kenton Co Court Clerk	43	0
Kenton Co Dog Authority	2	0
Kenton Co Magistrate	1	0
Kenton Co Police Dept	105	13
Kenton Co Public Library	65	4
Kenton Co Sheriff	4	0
Kenton Co Water Dist #1	91	4
Kenton County Airport Bd	264	10
Kenton County Attorney	38	0
Kenton County Fiscal Ct	147	20
Kenton County Sheriff	32	6
Kentucky Ed Dev Corp	39	0
Kentucky Educ Development	28	
Kentucky Emp Credit Union	24	0
Kentucky River Authority	8	0
Kentucky State University	445	17
Kentucky Valley Educ Coop	23	1
Knott Co Fiscal Ct	134	6
Knott Co Sheriff Dept	10	0
Knott Co Soil Conv Dist	1	0
Knott County Attorney	8	0
Knox Co E M S	42	0
Knox Co Fiscal Ct	87	4
Knox Co Soil Conserv Dis	1	0
Knox County Attorney	8	0
Ky Academic Association	2	
Ky Assoc For Comm Action	8	0
Ky Assoc Of Co (Kaco)	32	2
Ky Assoc Of Regional Prog	6	0
Ky Assoc Of School Admin	0	
Ky Co Judge/Ex Assoc	3	0
Ky Comm Economic Opport	107	0
Ky Council Of Add'S	2	0
Ky High School Athletic A	5	
Ky League Of Cities	30	0
Ky Legal Service Programs	1	0
Lou Labor Manager Com	2	0
Lou Police Retire Fund	1	0
Louisa Water & Sewer Comm	17	0
Louisville Airport Author	155	0
Louisville Conv Bureau	46	1
Louisville Mem Comm	3	0
Louisville Water Company	468	151
Lyndon Fire Protect Dist	25	0
Lyon Co Ambulance Service	8	0
Lyon Co Housing Authority	8	1
Lyon Co Pub Library Dist	3	1
Lyon Co Riverport Authori	2	0
Lyon Co Water District	1	0
Lyon County Fiscal Court	28	2
Madison Co Ambulance Ser	51	3
Madison Co Child Support	23	0
Madison Co Conservat Dist	1	0
Madison Co Fire Dept	32	6

Agency Name	# of Actives	# of Retirees
Laurel Co Conserv Dist	2	0
Laurel Co Public Lib Dist	13	0
Laurel Co Water Dist #2	21	1
Laurel County Attorney	9	0
Laurel County Fiscal Cour	216	8
Lawrence Co Fiscal Ct	71	1
Lawrence County Attorney	7	0
Lebanon Housing Authority	7	0
Lebanon Water Works	11	0
Lee Co Public Library	2	0
Lee Co Soil Conserv Dist	1	0
Lee County Attorney	3	0
Lee County Fiscal Court	57	3
Legal Aid Society Inc	37	0
Leitchfield Utility Comm	33	2
Leslie Co Fiscal Court	60	1
Leslie Co Public Library	3	1
Leslie County Attorney	2	0
Letcher Co Fiscal Court	128	6
Letcher County Attorney	6	0
Letcher County Cons Dist	1	0
Letcher County Fiscal Ct	4	0
Lewis County Fiscal Court	50	2
Lex-Fay Co Hum Rights Com	6	0
Lex/Fay Urban Co Atty Off	50	2
Lex/Fayette Urban Co Govt	1493	201
Lexington Public Library	98	4
Lfuc Housing Authority	71	5
Lfucg Com Corr Dept	276	0
Licking Valley Com Action	110	3
Lifeskills Inc	386	13
Lincoln Advocacy Support	9	0
Lincoln Co Fiscal Court	74	7
Lincoln County Attorney	4	0
Lincoln Domestic Viloence	21	0
Lincoln Trail Area Dev Di	33	0
Little Ky Rv Ws Conv Dist	1	0
Livingston Co Attorney	3	0
Livingston Co Conserv Dis	1	0
Livingston Co Fiscal Ct	59	7
Lklp Comm Action Council	311	10
Logan Co Cons District	2	0
Logan Co Public Library	12	0
Logan County Attorney	8	0
Logan County Fiscal Court	102	4
Logan/Todd Reg. Water Com	2	0
London Laurel Co Comm Ctr	10	0
London Laurel Tourist Com	3	0
London Utility Comm	33	2
London-Laurel Co Ida	3	0
London/Corbin Airport Bd	0	0
Lou & Jeff Co Riverport	4	0
Lou & Jeff Com Action Agy	23	2
Lou Firefighters Pens Fun	3	0
Menifee Co Fiscal Court	42	1
Menifee County Attorney	3	0
Mercer Co Public Library	9	0
Mercer County Attorney	6	0
Mercer County Fiscal Cour	48	4
Metcalfe Co Conserv Dist	1	0
Metcalfe Co Fiscal Court	37	3
Metcalfe Co Nursing Home	59	4
Metcalfe Co Public Lib	3	0
Metcalfe County Attorney	4	0
Middle Ky River Area Dev	99	5
Middlesboro Police & Fire	48	21
Middlesboro/Bell Co Lib	3	0
Middletown Fire Prot Dist	40	2
Monroe Co	3	0
Monroe Co Conserv Dist	2	0
Mont Co Fire Pro District	28	0
Montgomery Co Amb Dist	11	0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
Madison Co Fiscal Court	247	13
Madison Co Public Library	17	0
Madison Co Sheriff	15	0
Madison Co Utilities Dist	12	0
Magoffin Co Court Clerk	5	0
Magoffin Co Library	2	0
Magoffin Co Water Dist	9	0
Marion Co Conservat Dist	1	0
Marion Co Fiscal Court	97	5
Marion Co Sheriffs Dept	6	1
Marion Free Public Librar	6	1
Marshall Co Fiscal Court	168	19
Marshall Co Fiscal Ct Ems	4	2
Marshall Co Pub Library	6	0
Marshall Co Ref Disp Dist	24	1
Marshall Co Sen Citizens	6	0
Marshall Co Soil & Water	1	0
Marshall Co Tourist & Con	2	0
Marshall County Attorney	1	0
Marshall/Calloway Mas Com	3	0
Martin Co Conserv Dist	1	0
Martin Co Fiscal Court	65	4
Martin Co Housing Auth	2	0
Martin Co Water District	6	0
Martin County Attorney	6	0
Martin County Library	5	0
Mary W Weldon Mem Pub Lib	4	0
Mason Co Fis Ct	54	3
Mason Co Fiscal Court	31	2
Mason County Attorney	0	0
Mason County Library	6	0
Master Com James Carnahan	1	0
Master Comm Gary E Conn	1	0
Master Comm Ohio County	5	0
Master Commissioner	27	1
Mayfield Elec & Water Sys	39	9
Maysville & Mason Co Cem	3	0
Maysville Utility Comm	25	3
Mccracken Co Fiscal Ct		8
Mccracken Co Juvenile	1	3
Mccracken Co Public Libra		0
Mccracken Co Sher&Jailer	90	1
Mccracken County Attorney	8	0
Mccreary Co Fiscal Ct	75	1
Mccreary Co Water Dist	23	0
Mccreary County Attorney	3	0
Mclean County Fiscal Ct	60	1
Meade Co Public Library	5	1
Meade Co Water District	9	0
Meade County Attorney	6	1
Meade County Fiscal Court	135	4
Nicholas County Attorney	1	0
Nicholas County Library	2	1
Nicholasville Housing Aut	3	0
North Nelson Water Dist	4	2
North Shelby Water Co	6	0
Northern Ky Area Dev Dist		2
Northern Ky Conv Ctr Corp	20	0
Northern Ky Coop Ed Ser	30	1
Northern Ky Electric Auth	1	0
Northern Ky Reg Mhmr Bd	227	13
Northern Ky University	901	41
Northern Ky Water Ser Dis	153	15
Oakwood Canteen Inc	3	0
Office Of Geographic Info	2	0
Office Of Program Admin	2	0
Office Of Sec Of Work For	8	2
Office Of The New Economy	1	0
Ohio Co Library	9	0
Ohio Co Water Dist	21	1
Ohio County Fiscal Crt	101	2
Ohio Valley Educ Cooperat	52	

Agency Name	# of Actives	# of Retirees
Montgomery Co Attorney	5	0
Montgomery Co Fiscal Ct	105	3
Montgomery Co San Dist #2	1	0
Montgomery Cty Water Dist	2	0
Monticello Elec Plant Bd	11	0
Monticello Utility Comm	31	0
Morehead Fire Department	1	0
Morehead State University	925	102
Morehead Utility Plant Bd	41	3
Morehead/Rowan Co E M S	33	0
Morgan Co Ambulance Serv	42	0
Morgan Co Conservat Dist	1	0
Morgan Co Fiscal Court	48	0
Morgan Co Water Dist	5	0
Morgan County Attorney	3	0
Morgan County Library	2	0
Mountain Arts Center	9	0
Mountain Comp Care Center	309	2
Mountain Water District	58	2
Mt Sterl/Montgomery Lib	4	1
Mt Sterling Water Works	23	8
Muhlenberg Co Attorney	1	0
Muhlenberg Co Fiscal Ct	119	9
Muhlenberg Co Lib Bd Dist	10	0
Muhlenberg Co Water Dist	20	1
Muhlenberg Co.Health Dept	21	0
Muhlenberg Water Dist #3	8	3
Multi Purpose Comm Action	28	1
Mun Elec Pow Assoc Of Ky	2	1
Murray Electric System	33	5
Murray Police & Fire	58	24
Murray State Univ	545	49
Murray State University	484	11
Murray Tourism Commission	1	0
Murray/Calloway Co Airprt	1	0
Murray/Calloway Trans Aut	6	1
N Central Ky Reg Covingto	0	0
N Ky Area Dev Council	93	4
N Ky Area Plan Commission	33	0
N Ky Community Act Comm	83	1
N Ky Conv & Visitors Bur	14	0
N Ky Coop For Educ Servic	20	
N Ky Legal Aid Society	30	0
National Guard	1	0
Nelson Co Fiscal Court	99	9
Nelson Co Public Library	8	1
Nelson County Attorney	11	0
Newport Police & Fire	89	31
Nich-Vle/Jess Co Pk & Rec	12	0
Nicholas Co Fiscal Court	44	6
Nicholas Co Water Dist	1	0
Personal Service Co	7	0
Pike Co Bd Of Education	0	1
Pike Co Clerk	27	0
Pike Co Housing Authority	6	0
Pike Co Library District	18	1
Pike Co Sheriff	45	1
Pike County Attorney	19	0
Pike County Fiscal Court	269	16
Pineville Utility Comm	24	0
Pineville/Bell Co Pub Lib	2	0
Pleasure Ridge Park Fire	21	0
Powell Co Fiscal Ct	64	1
Powell County Attorney	5	0
Powells Valley Water Dist	5	1
Prestonsburg City Util	37	4
Princeton Electric Pl Bd	19	3
Princeton Water/Wastewate	19	0
Providence Mun Housing Au	2	0
Pulaski Co Fiscal Court	196	13
Pulaski Co Soil Cons Dist	2	0
Pulaski County Attorney	15	0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
Okolona Fire District	51	0
Okolona Sewer	0	0
Oldham Co Ambl Tax Dist	20	0
Oldham Co Eco Dev Auth	1	0
Oldham Co Fiscal Court	107	4
Oldham Co Jail	23	0
Oldham Co Library Bd	13	0
Oldham Co Master Comm	1	0
Oldham Co Sanitation Dist	2	0
Oldham Co Sheriff Dept	11	3
Oldham Co Water Dist	14	1
Oldham County Attorney	5	0
Oldham County Police Dept	29	7
Owen Co Memorial Hospital	46	0
Owen Co Public Library	3	0
Owen County Attorney	2	0
Owen County Fiscal Court	47	1
Owensboro Daviess Co Tour	4	0
Owensboro Metro Plan Comm	19	1
Owensboro Mun Utilities	235	73
Owensboro Police & Fire	196	69
Owensboro Riverport Auth	40	0
Owsley Co Fiscal Court	29	1
Owsley Co Public Library	3	0
Paducah Mccracken Co Tour	7	0
Paducah Police & Fire	138	65
Paducah Power System	66	22
Paducah Water Works	56	18
Paducah-Hccracken Co Riv		0
Paducah-Mccracken Co Join	35	0
Paintsville Gas/Water Sys	32	2
Paris Bourbon Co Library	6	0
Paul Sawyer Public Librar	13	0
Pendleton Co Fiscal Court	29	1
Pendleton Co Ind Dev Auth	1	0
Pendleton Co Library	3	0
Pendleton Co Sheriff Offi	5	0
Pendleton County Attorney	4	0
Pendleton County Water	8	1
Pennyrile Allied Comm Ser	116	0
Pennyrile Area Devp Dist	43	5
Pennyrile Nar Task Force	9	0
Pennyroyal Area Museum	2	0
Pennyroyal Reg Mhmr Bd	174	12
Pennyroyal Region Mental	1	
Perry County Fiscal Court	112	7
Perry County Public Lib	8	0
Perryville Police Dept	1	0
Shelby County Attorney	6	0
Shelby County Library		0
Shelbyvle Mun Water&Sewer	23	1
Shepher/Bullit Co Tourist	7	0
Simpson Co Conser Dist	1	0
Simpson Co Fiscal Court	75	2
Simpson Co Library Dist	7	0
Simpson County Attorney	4	0
Somerset Police & Fire	60	27
Somerset Pul Co 911 C Ctr	12	0
Somerset Pulaski Co Ems	35	0
Somerset-Pulaski Conv & V	3	0
South Hopkins Water Dist	6	0
South Ky Region Somerset	0	0
South Oldham Fire Dept	9	0
Southern Madison Water Dt	9	0
Spencer Co Fire Dist	1	0
Spencer Co Public Lib	3	0
Spencer Co Treasurer	50	2
Spencer County Attorney	3	0
Springfield Water & Sewer	14	1
St Matthews Fire Dist.	37	2
Stanford Water Commission	12	1
Stanton City Police	12	1

Agency Name	# of Actives	# of Retirees
Pulaski County Library	15	0
Purchase Area Dev Dist	70	2
Qtr Horse & Appal Commis	5	0
Real Estate Commission	12	0
Regional Public Safety	15	0
Regional Wtr Resource Agy	72	3
Registry Of Elect Finance	1	0
Reidland Water District	6	0
Richmond Police & Fire	104	51
Richmond Utilities	65	10
Ridgway Memorial Library	18	0
Riverpark Ctr Owensboro	19	0
Robertson Co Fiscal Ct	21	1
Robertson County Attorney	0	0
Rockcastle Co Attorney	4	0
Rockcastle Co Fiscal Ct	62	2
Rockcastle Conserv Dist	1	0
Rowan Co Detention Center	13	0
Rowan Co Fiscal Court	63	1
Rowan County Attorney	6	0
Rowan County Sheriff	21	0
Russell Co Ambulance Ser	16	0
Russell Co Cons Dist	1	0
Russell Co Fiscal Court	47	1
Russell Co Public Library	6	0
Russell Co Tourist Comm	2	0
Russell County Attorney	5	0
Russellville Elec Pl Bd	12	0
S Dixie Fire Protect Dist	4	0
Sandy Valley Trans Ser In	28	0
Sanitation District N0 1	171	10
School Building Authority	1	0
Scott Co Detention Center	55	2
Scott Co Emer Medical Ser	28	2
Scott Co Fire Dept	25	0
Scott Co Fiscal Ct	86	1
Scott Co Soil Conser Dist	2	0
Scott County Attorney	13	1
Scott County Library	12	2
Secretary Of The Cabinet	8	0
Seven Co Services Inc	1120	15
Shelby Co Detention Cntr	39	0
Shelby Co Ems	32	2
Shelby Co Fiscal Court	61	2
Shelby Co Library	7	0
Shelby Co Park Recreation	11	0
Shelby Co Sheriff	25	0
Shelby Co Sub Fire Dist	1	0
Union County Sheriff	7	0
Union Emergency Services	17	0
Vanceburg Mayor/City Clrk	10	1
Versailles/Woodford Co Pk	8	0
W Mccracken Co Water Dist	3	0
W Shelby Water District	3	0
Walton Fire Dist/Ems	23	0
Washington Co Attorney	2	0
Washington Co Conser Dist	1	0
Washington Co Fis Court	42	2
Washington Co Library Bd	3	0
Washington Co Sheriff&Jlr	5	0
Wayne Co Conserv Dist	2	0
Wayne Co Public Library	5	0
Wayne County Attorney	4	0
Wayne County Fiscal Court	56	0
Webster Co Fiscal Court	73	0
Webster Co Public Library	4	0
Webster County Attorney	0	0
Webster County Water Dist	12	0
West Kentucky Educ Cooper	24	
West Ky Corporation	6	0
West Point Independent Sc	9	0
West Pulaski Water Distr	6	0

Entities with Only Retirees Participating in Commonwealth Group

Agency Name	# of Actives	# of Retirees
State Police Arson Unit	19	6
Sturgis Housing Authority	2	0
T A R C	641	85
Taylor Co Public Library	8	0
Taylor Co Sheriff Dept	10	0
Taylor County Attorney	4	0
Taylor County Fiscal Cour	51	3
Todd County Attorney	3	0
Todd County Fiscal Court	46	0
Todd County Water Dist	6	0
Treasury Special Pay	10	0
Tri Co Comm Action Agency	12	0
Tri Village Water Dist	5	0
Trigg Co Cons District	1	0
Trigg County Attorney	5	0
Trigg County Fiscal Court	53	1
Trimble Co Fiscal Court	33	1
Trimble Co Library	4	0
Trimble Co Sheriff Dept	1	0
Trimble County Attorney	2	0
Triple S Planning & Zonin	2	0
Union Co Library Bd	4	0
Union Co Planning Comm	2	0
Union County Attorney	3	0
Union County Fiscal Court	64	3
Western Kentucky Univ	1054	139
Western Ky Reg Mhmr Adv	175	6
Western Lewis-Rectorville	4	0
Whitley Co Conserv Dist	1	0
Whitley Co Fiscal Court	90	4
Whitley Co Sheriff	10	2
Whitley County Attorney	6	0
Whitley/Mccreary Mas Comm	1	0
Winchester Municipal Util	77	0
Winchester Police & Fire	87	38
Withers Memorial Library	18	0
Wolfe Co Fiscal Court	35	1
Wolfe County Attorney	5	0
Wolfe County Library	2	0
Woodcreek Water District	43	1
Woodford Co Conserv Dist	1	0
Woodford Co Ems	12	0
Woodford Co Fiscal Court	122	4
Woodford Co Plan Zoning	4	0
Woodford Co Police	19	4
Woodford County Attorney	6	0
Woodford County Library	10	1
Woodford County Sheriff	6	3
Woodford Fire Protection	2	0
Worthington Fire Dept	31	0
Grand Total	57661	5820

2001 Commonwealth Group Plan Choices By County

County	HMO	POS	PPO	EPO	Total
Adair	2	2	4	2	10
Allen	2	2	6	3	13
Anderson	6	6	4	3	19
Ballard	2	2	4	2	10
Barren	2	2	6	3	13
Bath	6	6	2	3	17
Bell	6	6	2	3	17
Boone	4	4	2	3	13
Bourbon	6	6	4	3	19
Boyd	2	2	2	2	8
Boyle	6	6	4	3	19
Bracken	6	6	2	3	17
Breathitt	4	4	4	3	15
Breckinridge	2	2	2	2	8
Bullitt	6	6	2	3	17
Butler	2	2	6	3	13
Caldwell	2	2	4	2	10
Calloway	2	2	4	2	10
Campbell	4	4	2	3	13
Carlisle	2	2	4	2	10
Carroll	4	4	2	2	12
Carter	2	2	2	2	8
Casey	4	4	4	3	15
Christian	-	-	2	1	3
Clark	6	6	4	3	19
Clay	6	6	2	3	17
Clinton	2	2	2	2	8
Crittenden	2	2	4	2	10
Cumberland	-	-	2	1	3
Daviess	-	-	2	1	3
Edmonson	2	2	6	3	13
Elliott	2	2	2	2	8
Estill	6	6	4	3	19
Fayette	6	6	4	3	19
Fleming	6	6	4	3	19
Floyd	4	4	2	2	12
Franklin	6	6	4	3	19
Fulton	2	2	4	2	10
Gallatin	4	4	2	3	13
Garrard	6	6	4	3	19
Grant	4	4	2	3	13
Graves	2	2	4	2	10
Grayson	2	2	2	2	8
Green	2	2	4	2	10
Greenup	2	2	2	2	8
Hancock	-	-	2	1	3
Hardin	4	4	2	3	13
Harlan	2	2	-	1	5
Harrison	6	6	4	3	19
Hart	4	4	4	3	15
Henderson	-	-	2	1	3
Henry	6	6	2	3	17
Hickman	2	2	4	2	10
Hopkins	-	-	2	1	3
Jackson	4	4	4	3	15
Jefferson	6	6	2	3	17
Jessamine	6	6	2	3	17
Johnson	4	4	4	3	15
Kenton	4	4	2	3	13
Knott	6	6	2	3	17
Knox	4	4	4	3	15
Larue	4	4	2	3	13
Laurel	4	4	4	3	15
Lawrence	2	2	2	2	8
Lee	4	4	4	3	15
Leslie	6	6	2	3	17
Letcher	4	4	4	3	15
Lewis	4	4	-	2	10
Lincoln	6	6	4	3	19
Livingston	2	2	4	2	10
Logan	2	2	6	3	13
Lyon	2	2	6	3	13
Madison	6	6	2	3	17
Magoffin	4	4	4	3	15
Marion	6	6	4	3	19
Marshall	2	2	4	2	10
Martin	4	4	4	3	15
Mason	4	4	-	2	10
McCracken	2	2	4	2	10
McCreary	2	2	4	2	10
McLean	-	-	2	1	3
Meade	6	6	2	3	17
Menifee	6	6	4	3	19
Mercer	6	6	4	3	19
Metcalfe	2	2	4	2	10
Monroe	2	2	4	2	10
Montgomery	6	6	4	3	19
Morgan	2	2	2	2	8
Muhlenburg	-	-	2	1	3
Nelson	6	6	2	3	17
Nicholas	6	6	4	3	19
Ohio	-	-	2	1	3
Oldham	6	6	2	3	17
Owen	6	6	4	3	19
Owsley	4	4	4	3	15
Pendleton	4	4	2	3	13
Perry	4	4	-	2	10
Pike	4	4	2	2	12
Powell	6	6	4	3	19
Pulaski	-	-	2	1	3
Robertson	4	4	-	2	10
Rockcastle	4	4	4	3	15
Rowan	4	4	2	2	12
Russell	4	4	2	3	13
Scott	6	6	2	3	17
Shelby	6	6	2	3	17
Simpson	2	2	6	3	13
Spencer	6	6	2	3	17
Taylor	-	-	2	1	3
Todd	-	-	2	1	3
Trigg	-	-	2	1	3
Trimble	6	6	2	3	17
Union	-	-	2	1	3
Warren	2	2	6	3	13
Washington	6	6	4	3	19
Wayne	4	4	2	3	13
Webster	-	-	2	1	3
Whitley	4	4	4	3	15
Wolfe	4	4	4	3	15
Woodford	6	6	4	3	19

2001 Commonwealth Public Employee Health Insurance Program Benefit Provisions

HMO Plans		Option A	Option B
Annual Deductible		None	None
Maximum Out-of-Pocket for Covered Expenses	Co-insurance amounts for dental, vision audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $1,500 Family: $3,000
Lifetime Maximum Benefit		Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas, mental health and chemical dependency services. (Co-pays are per admission.)	$100 co-pay	$250 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	$20 co-pay
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay-a separate diagnostic testing co-pay will not apply.	$10 co-pay	$20 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit)-outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay	$125 co-pay
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$50 co-pay	$50 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$20 co-pay	$30 co-pay
	Ambulance (per use)	20% co-insurance	25% co-insurance
Maternity Care	Prenatal, labor, delivery, postpartum care and one ultra sound per pregnancy. More than one ultra sound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	$20 co-pay Hospital in-patient co-pay also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	$10 generic $15 brand $30 non-formulary
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person, per plan year; one set of bitewing x-rays per person per plan year.	50% co-insurance; $100 maximum benefit per plan year.	Not covered
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-insurance; $75 maximum benefit per plan year.	Not covered
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-insurance	Not covered
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay	$20 co-pay
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-insurance	25% co-insurance
	Home Health	20% co-insurance; Limit 60 visits per year.	25% co-insurance; Limit 40 visits per year.
	Hospice – Certain limits apply (see Certificate of Coverage). Must be precertified by Plan.	Covered same as Medicare benefit.	Covered same as Medicare benefit.
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	$20 co-pay
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	$250 co-pay

2001 Commonwealth Public Employee Health Insurance Program Benefit Provisions

POS Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		None	Single: $500 Family: $1,000	None	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Coinsurance amounts for dental, vision audiometric and Autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $1,000 Family: $2,000	Single: $2,500 Family: $5,000	Single: $1,500 Family: $3,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	$100 co-pay (per admission)	40% co-ins*	$250 co-pay (per admission)	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit), visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, immunizations, injections, lab fees, and x-rays, and mental health/chemical dependency services. Annual gynecological exam, routine physical, and certain early detection tests (age and periodicity limits may apply). All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Diagnostic Testing (per visit)-laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay-a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit)-outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$50 co-pay (per visit)	40% co-ins*	$125 co-pay (per visit)	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay (per visit)	$50 co-pay plus 40% co-ins	$50 co-pay (per visit)	$50 co-pay plus 50% co-ins
	Emergency Room Physician	Covered in full	40% co-ins	Covered in full	50% co-ins
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance	20% co-ins	20% co-ins	25% co-ins	25% co-ins
Maternity Care	Prenatal, labor, delivery, postpartum care and one ultra sound per pregnancy. More than one ultra sound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed	$10 co-pay Hospital in-patient co-pay also applies.	40% co-ins* Hospital in-patient co-ins* also applies.	$20 co-pay Hospital in-patient co-pay also applies.	50% co-ins* Hospital in-patient co-ins* also applies.
Prescription Drugs	Co-pay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins		Not covered	
	Autism – $500 maximum monthly benefit for children 2 - 21 years of age for therapeutic, respite and rehabilitative care.	50% co-ins		50% co-ins	
	Chiropractor (per visit) – No referral is necessary. Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	$20 co-pay (per visit)	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins	20% co-ins	25% co-ins	25% co-ins
	Home Health	20% co-ins Limit 60 visits per year.	20% co-ins	25% co-ins Limit 40 visits per year.	25% co-ins
	Autism Respite Services-$500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-insurance	50% co-insurance	50% co-insurance	50% co-insurance
	Hospice – Certain limits apply (see Certificate of Coverage). Must be precertified by Plan.	Covered	Covered	Covered	Covered
	Physical Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	$10 co-pay	40% co-ins*	$20 co-pay	50% co-ins*
	Skilled Nursing Facility (per admission) – Limit 30 days per year.	$100 co-pay	40% co-ins*	$250 co-pay	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service. Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.

2001 Commonwealth Public Employee Health Insurance Program Benefit Provisions

PPO Plans		Option A		Option B	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible		Single: $250 Family: $500	Single: $500 Family: $1,000	Single: $500 Family: $1,000	Single: $1,000 Family: $2,000
Maximum Out-of-Pocket for Covered Expenses (including deductible)	Co-payments for office visits, prescription drugs, hospital emergency room visits, urgent care center visits and coinsurance amounts for dental, vision, audiometric and Autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits.	Single: $1,250 Family: $2,500	Single: $2,500 Family: $5,000	Single: $2,000 Family: $4,000	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited	Unlimited	Unlimited	Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Outpatient Services	Physician or Mental Health Provider Office (per visit)- visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy well childcare, immunizations, injections, lab fees, x-rays, and mental health/chemical dependency services. All services performed on the same day (same site) are subject to one co-pay.	$10 co-pay	40% co-ins*	25% co-ins*	50% co-ins*
	Annual gynecological exam, routine physical, and certain early detection tests. Age and periodicity limits may apply.	$10 co-pay (per visit) $400 maximum benefit per year	40% co-ins*	$20 co-pay (per visit) $300 maximum benefit per year	50% co-ins*
	Diagnostic Testing (per visit)- laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay- a separate diagnostic testing co-pay will not apply.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
Emergency Services	Hospital Emergency Room – $50 co-pay per visit is waived if admitted. In-hospital co-insurance applies.	$50 co-pay plus 20% co-ins	$50 co-pay plus 40% co-ins	$50 co-pay plus 25% co-ins	$50 co-pay plus 50% co-ins
	Emergency Room Physician	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Urgent Care Center (not hospital emergency room)	$20 co-pay (per visit)	40% co-ins*	$30 co-pay (per visit)	50% co-ins*
	Ambulance	20% co-ins*	20% co-ins*	25% co-ins*	25% co-ins*
Maternity Care	Prenatal, labor, delivery, postpartum care and one ultra sound per pregnancy. More than one ultra sound per pregnancy is only covered with prior Plan approval. Office visit co-pay only applies to visit in which pregnancy is diagnosed.	$10 co-pay Hospital in-patient co-ins also applies.*	40% co-ins*	25% co-ins* Hospital in-patient co-ins also applies.*	50% co-ins*
Prescription Drugs	Copay applies to each 1-month supply. Pre-authorization may be required for certain drugs. Drugs are not available for non-covered services.	$10 generic $15 brand $30 non-formulary	40% co-ins*	$10 generic $15 brand $30 non-formulary	50% co-ins*
Dental	Preventive dental only. Limited to two oral exams and two routine cleanings per person per plan year. One set of bitewing x-rays per person per plan year.	50% co-ins* $100 maximum benefit per year		Not covered	
Vision	One routine eye exam visit per plan year for persons under 18. One routine eye exam every other year for persons 18 and older.	50% co-ins* $75 maximum benefit per year		Not covered	
Other Services	Audiometric – Only covered in conjunction with a disease, illness or injury.	50% co-ins*		Not covered	
	Chiropractor – Limit of 26 visits per year with no more than one visit per day.	$10 co-pay (per visit)	40% co-ins*	25% co-ins*	50% co-ins*
	Durable Medical Equipment (DME) and Prosthetic Devices	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Home Health	20% co-ins* Limit 60 visits per year.	40% co-ins*	25% co-ins* Limit 40 visits per year.	50% co-ins*
	Autism Respite Services – $500 maximum monthly benefit. For children 2 to 21 years of age for respite and rehabilitative care.	50% co-ins*	50% co-ins*	50% co-ins*	50% co-ins*
	Hospice – Certain limits apply (see Certificate of Coverage). Must be precertified by Plan.	Covered	Covered	Covered	Covered
	Physical Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Occupational Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Cardiac Rehabilitation Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Speech Therapy (per visit) – Limit 30 visits per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*
	Skilled Nursing Facility (per visit) – Limit 30 days per year.	20% co-ins*	40% co-ins*	25% co-ins*	50% co-ins*

*Deductible applies. Once deductible is met, the member pays the percentage of co-insurance that is indicated for that service.Note: Visit limits and/or dollar limits are applied on a combined basis when both in-network and out-of-network benefits are offered.

2001 Commonwealth Public Employee Health Insurance Program Benefit Provisions

Exclusive Provider Option		Option C
Annual Deductible		None
Maximum Out-of-Pocket for Covered Expenses	Coinsurance amounts for dental, vision, audiometric and autism respite services do not apply to the out-of-pocket limits. Co-payments for prescription drugs do not apply to the out-of-pocket limits. All other co-payments and co-insurance amounts do apply.	Single: $4,000 Family: $8,000
Lifetime Maximum Benefit		Unlimited
In Hospital Care	Provider services, inpatient care, semi-private room, transplant coverage (kidney, cornea, bone marrow, heart, liver, lung, heart/lung, and pancreas), mental health and chemical dependency services. (Co-pays are per admission.)	$1,500 co-pay
Outpatient Services	Physician or Mental Health Provider Office (per visit) – visit, diagnostic and allergy testing, allergy serum and injections, diabetes education and therapy, well childcare, injections, lab fees, x-rays and mental health and chemical dependency services. Annual gynecological exam and associated Pap test. Adult physical exam – visit only – see Preventive Testing below. All services performed on the same day (same site) are subject to one co-pay.	$25 co-pay
	Ambulatory Hospital and Outpatient Surgery (per visit) – outpatient surgery services (including biopsies), radiation therapy, renal dialysis, chemotherapy and other outpatient services not listed under diagnostic testing performed in a hospital or other ambulatory center (other than a physician's office).	$500 co-pay
	Diagnostic Testing (per visit) – laboratory, x-ray and other radiology/imaging services, ultrasound and approved machine testing services performed for the purpose of diagnosing an illness or injury. All services performed on the same day (same site) are subject to one co-pay. Services received in a physician's office in conjunction with an office visit are only subject to the physician office visit co-pay – a separate diagnostic testing co-pay will not apply.	$25 co-pay
	Preventive Testing* – Covered at Health Departments only. Mammograms, cholesterol screenings, glucose serum testing, and PSA.	50% co-insurance
	Immunizations* – All early childhood immunizations; flu, pneumonia and tetanus vaccinations for adults.	50% co-insurance
Emergency Services	Hospital Emergency Room (per visit) – Co-pay is waived if admitted and in-hospital co-pay applies. Emergency physician covered in full.	$75 co-pay
	Urgent Care Center (not hospital emergency room) (per visit)	$50 co-pay
	Ambulance	$75 co-pay
Maternity Care	Prenatal, labor, delivery, postpartum care and one ultra sound per pregnancy. More than one ultra sound per pregnancy is only covered with prior Plan approval.	$25 co-pay (per visit) Hospital in-patient co-pay also applies.
Prescription Drugs	Copay applies to each 1-month supply. Preauthorization may be required for certain drugs. Drugs are not covered for non-covered services.	$25 generic $35 brand $50 non-formulary
Dental		Not covered
Vision		Not covered
Other Services	Audiometric	Not covered
	Chiropractor	50% co-insurance Limit 15 visits per year.
	Durable Medical Equipment (DME) and Prosthetic Devices	50% coinsurance
	Home Health	Covered in full. Limit 20 visits per year.
	Autism – $500 maximum monthly benefit for children 2 - 21 years of age for therapeutic, respite and rehabilitative care.	50% co-insurance
	Hospice – Certain limits apply (see Certificate of Coverage). Must be precertified by Plan.	Covered same as Medicare benefit.
	Physical Therapy (per visit) – Limit 20 visits per year.	$30 co-pay
	Occupational Therapy (per visit) – Limit 20 visits per year.	$30 co-pay
	Cardiac Rehabilitation Therapy (per visit) – Limit 20 visits per year.	$30 co-pay
	Speech Therapy (per visit) – Limit 20 visits per year.	$30 co-pay
	Skilled Nursing Facility (per admission) – Limit 20 days per year.	$1,500 co-pay

*Health Departments shall be given the right of first refusal. Note: Only services from network providers are covered.

2001 Members of
Advisory Committee of State Health Insurance Subscribers

Name	**Represents**
Carolyn Bradshaw	Supreme Court District 5
Pat Doyle	Coalition of State Employees
Debbie Foreman	School District – Region 2
Scotty Fugate	Supreme Court District 3
Judith Gambill	Kentucky Education Association
Kelly Gamble	School District – Region 6
Sue Gill	KTRS - Retirees Under Age 65
Wayne Hafer	Member At Large
Cordelia Hardin	School District – Region 4
Sharon Harmon	School District – Region 7
David Jackson	Coalition of State Employees
Lee Jackson	KASE
Linda Kerr	Supreme Court District 2
Thomas Loving	Member at Large
Linda May	Supreme Court District 7
Mark McKinney	KASE
Paula Moore	KRS Retirees Under Age 65
John Moreland III	Member at Large
Byron Powers	KTRS Retirees Under Age 65
Amalie Preston	Health Departments
John Ruflil	Supreme Court District 1
Robert E. Spillman	School District – Region 1
Larry Taylor	School District - Region 3
Becky Wallace	Supreme Court District 6
Barbara Whitley	Supreme Court District 4
John Wilkerson	Kentucky Education Association
Ken Wright	School District - Region 5
Rita Young	KRS Retirees Under Age 65

2001 Members of the Kentucky Group Insurance Board

Name	**Agencies**
Carol M. Palmore	Secretary, Personnel Cabinet
Kevin Flanery	Secretary, Finance and Administration Cabinet
Dr. James Ramsey	State Budget Director, Governors Office for Policy and Management
Edward Hatchett, Jr.	State Auditor, Auditor of Public Accounts
Janie Miller	Commissioner, Kentucky Department of Insurance
Gene Wilhoit	Commissioner, Department of Education
Thomas Loving	Chair, Kentucky Drug Task Force